EXHIBIT D

UNITED STATES DISTRICT COURT

FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

PLANNED PARENTHOOD SOUTH ATLANTIC, et al., Plaintiffs	)
vs.	)
JOSHUA STEIN, et al., Defendants	)
and	)
PHILIP E. BERGER, et al., Intervenor-Defendants	)

REMOTE DEPOSITION

OF

SUSAN BANE, M.D., Ph.D.

January 31, 2024, 1:33 P.M.

PREPARED BY: Susan A. Hurrey, RPR

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and Legal Videographers, LLC

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Meghan Fernandez

Ellis Foxwood

Vanisha Kudumuri

Shealyn Massey

Tallin Moyer

Elizabeth O'Brien

Ella Spottswood

I N D E X

E X A M I N A T I O N S

E X H I B I T S

SUSAN BANE, M.D., Ph.D., after having been first duly sworn, was examined and testified as follows:

BY MS. PAI-THOMPSON:

Q. So Dr. Boyle -- Dr. Bane, I'm sorry. I was of course looking at Mr. Boyle's name and you'll see me drinking coffee during our deposition and you'll understand why. I'm on the West Coast, so it's early for me. Still early for me.

So my name is Vanessa Pai-Thompson and I am one of the lawyers representing Planned Parenthood South Atlantic in this case.

A. Nice to meet you.

Q. Nice to meet you as well. So I'm going to begin by just kind of going through some of what I'll think of as our agreed ground principals for the deposition. A lot of this will be duplicative of what you went over on August 31st of last year, but we just have to do it again since we're back here again.

A. Okay.

Q. And so just beginning with your having taken an oath. Do you understand that the oath that you take here in a deposition is the same as taking an oath in court?

A. I do.

Q. And that we have our court reporter here helping us today who will be taking down everything that you say and everything that I or Mr. Boyle say.

A. I do understand that.

Q. Thanks. And if at any point if you realize you made a mistake, that's completely fine. Just let me know and we can clarify or correct anything so that you feel like the statement is accurate.

A. Okay.

Q. Throughout the deposition, just as you have been doing, since we do have a court reporter, if you can just make sure that all of your responses are verbal, in words, so like yes rather than uh-huh or a shake of the head.

A. Okay.

Q. And as we go through, I will ask you questions and you finish any responsive answers to those questions.

A. Okay.

Q. And that as part of that, I would just ask that you also let me complete my questions before beginning to respond to those questions.

A. I'll do that.

Q. At some point if it seems like -- and I don't anticipate that this will be something that will come up often, if at all, but just in case, if an answer doesn't respond to my question, it's possible that I will chime in just to ensure that my question was clear and that we have the same understanding of what I'm asking.

A. Okay.

Q. It may be that Mr. Boyle, at points during the deposition, makes an objection to a question that I have asked. That is for our record, but unless he instructs you not to answer the question, you're still to answer the question that I posed.

A. Correct.

Q. And we will be taking breaks. We will endeavor to take a break about every hour or so, but if you feel like you need a break or I have lost track of the clock, please let me know.

A. I will.

Q. And we won't break mid-question, but if you need a break at some point, we can finish up the question that we're doing and then give us a break in.

A. That makes sense.

Q. There are just two other things that I wanted to flag for you given the forum that we're in, because if it were me and this just happened, I could imagine it feeling disrespectful and I just want to make sure that you don't feel that way at any point during the deposition.

A. Okay.

Q. The first is that I will at some point probably be looking down or looking away from the camera and not at you. I am someone who will always use a certain amount of paper. So like you I have some paper documents in front of me as well.

So that's not a sign that I'm not listening or a sign of disrespect. It's just that I may be looking down from time to time.

A. Yeah. And I have a binder that has the documents from today -- my expert report. And then on this side is a binder with the documents from the first deposition and a few overlap. So if I'm going that way, that's what I'm doing.

Q. Fabulous. Thank you. I appreciate that. And I did just want to note if everyone who is observing can just check to make sure that they are muted so that we don't have any break in. I think there was one that just happened. So if folks can just double check, that would awesome.

The second thing is -- and this is really just to try to avoid us talking over one another potentially during the deposition because that makes it difficult for court reporters under any circumstances, but especially in a Zoom context. So it may be that at some point I put my hand up, if for example your audio goes out or I can't hear what you're saying just so that I'm not talking over you. That's not something I would ever do if we were in person together and I know it might feel weird. So I just want to let you know if I do that, that's why. Just so we're keeping the transcript as clean as we can.

A. Okay.

Q. So I now have some of the sort of background questions that feel a little bit awkward and uncomfortable to ask and I

imagine to answer but that are important for us to go through. So the first is whether you're dealing with any illness that would impact your memory or prevent you from being able to understand my questions today?

A. No, I am not.

Q. Thank you. Are you taking any substances that would impact your memory or prevent you from being able to understand my questions today, such as medication?

A. No, I'm not.

Q. Is there anything else that's currently impacting your ability to understand and answer my questions today?

A. No, it's not.

Q. Fabulous. Thank you. So can you please tell us -- I see that you're in an office. What city are you located in currently?

A. Wilson, North Carolina. And I'm actually in my basement of my house.

Q. Well, it's lovely and doesn't look like a basement. So mission accomplished.

A. You should see the rest of it.

Q. The Zoom background is all that matters.

A. Right.

Q. So just from your camera view, I don't see that there is any off-camera seating or anyone off camera in the room?

A. No, there's not.

Q. Thank you.

A. I will note, I have a son with special needs who gets off the bus at 2:30 and I share this space with him, but my husband's role is to not let him down here. But if somebody comes running past -- well, actually there's nobody behind me, but you might hear a few strange noises. But we'll work on avoiding that.

Q. Fabulous. And you actually foresaw my next question, which was just if anyone else enters the room at any point during the deposition, just let us know. It may be that that's a good time for us to take a break, if needed. So thank you for that.

A. Are there only four of us on the call?

Q. There are more of us on the call, but as observers. So at this point there is -- in terms of screens where you should see images, you should see myself, Mr. Boyle, our court reporter and then yourself, if you have yourself on camera.

A. Yeah. Okay.

Q. So have that view up.

A. I know last time there were a lot of people, but everybody was on the screen.

Q. Yeah. It's just -- I think it makes it less distracting. But yes, there are people who are observing -- you don't need to worry that there will be other screens popping up with random questions coming from everywhere. The

questions will be coming from me.

MR. BOYLE: Are we going to identify all the other folks, the lawyers?

MS. PAI-THOMPSON: We can certainly do that and I appreciate that reminder. Why don't we do that at this point.

MR. BOYLE: I might suggest -- and forgive if I'm saying it wrong -- Ms. Pai-Thompson, that you might represent or introduce all the various folks and then we cycle through the other sort of groups of attendants just because I don't know who all these other folks are.

MS. PAI-THOMPSON: Absolutely. And I think that I may also -- Hannah Swanson has just joined on video and she may provide me with an assist as well. But absolutely. I apologize for not doing that. I think one that we observed earlier we hadn't, but it's not at all intended to hide information about who is here.

So from my office, Planned Parenthood Federation of America, on the call is Cecilia Dos Santos, Ellis Foxwood, Hannah Swanson. I'm continuing to scroll. Shealyn Massey, Valentina De Fex and Vanisha Kudumuri.

And, Hannah, have I missed anyone in my scrolling through?

MS. SWANSON: I don't think so. I'll just note for the record that Anjali Salvador, Vanessa Pai-Thompson and

myself are the attorneys who rendered appearances in this case and everyone else is simply here as observers.

MS. PAI-THOMPSON: And then I would also note that Ryan Mendias who, Mr. Boyle, you have met in other proceedings is also here, the ACLU and is also counsel for the plaintiffs.

And I did notice also that Kyla Eastling with our office has just joined who again, is here just observing.

MS. MAFFETORE: Sorry, one last person. Jaclyn Maffetore from the ACLU of North Carolina. I'm on the call as well observing and I am counsel of record on the case.

MS. PAI-THOMPSON: Thank you, Jaclyn. And my apologies.

MR. THERIOT: I'm Kevin Theriot and I just entered an appearance as counsel of record for the defendants.

MR. BOYLE: And I'm Ellis Boyle and Mr. Theriot and I are counsel on behalf of the defendant intervenors legislative leaders.

MS. NARASIMHAN: This is Priya Narasimhan on behalf of Attorney General Stein, counsel for Attorney General Stein.

MR. WILLIAMS: This is Kevin Williams on behalf of defendant District Attorney Jim O'Neill.

MR. BULLERI: This is Michael Bulleri on behalf of the North Carolina Medical Board.

MS. CROWLEY: Colleen Crowley on behalf of the Department of Health and Human Services.

MS. PAI-THOMPSON: Have we covered everyone? Hearing nothing I will --

MR. BOYLE: Did we get Elizabeth O'Brien? If we did, I'm sorry. I missed --

MS. PAI-THOMPSON: No. No. Absolutely.

MS. NARASIMHAN: Elizabeth O'Brien works at the North Carolina Department of Justice and at least she is on the Zoom so -- this is Priya Narasimhan and I will represent that she represents the other defendant.

MS. PAI-THOMPSON: Fabulous. Thank you so much. I was just going to suggest that someone might have stepped away and we might just break if we needed to.

Any other appearances that you wanted to note, Mr. Boyle?

MR. BOYLE: I think that covered most everybody, if not everyone, hopefully.

MS. PAI-THOMPSON: Perfect. Thank you.

BY MS. PAI-THOMPSON:

Q. So Dr. Bane, then I'm going to kind of turn back to some of our initial questions. So we have gone through who's in the room with you, where you are. Can you describe to me what technology you're using to be part of this call?

A. Sure. I have a PC laptop and I think this is a Zoom

meeting. That's it.

Q. Fabulous. Do you have any other screens or just the one screen from your laptop?

A. Just one.

Q. Is there any other technology in the room with you?

A. So I do have my phone. It's upside down, but I do have, as I mentioned, a son with special needs so I like to keep it close by because he has seizures. In case the school calls me.

Q. Is it on silent?

A. I am getting ready to make sure. It is.

Q. Okay. And then understanding the reasons that it's important for you to have it there with you, if at any point you look at the screen of the phone if something comes in, can you please let us know right away?

A. I will.

Q. Perfect. And then we may have follow-up questions based upon that.

A. Okay. Can I do this? So I'll turn it over, but if I silence it that means I can't hear them text me. Would it be okay if I unmute it so I can have it turned over? It will be less distracting, I think.

Q. Yes. Our preference would be that the screen not be facing up. So yes, that's certainly fine.

A. Okay. I'm all set.

Q. And then this is just kind of following up on what we were talking about. Do you agree not to communicate with anyone while we're on the record, other than communications that are being transcribed by the court reporter?

A. Absolutely. Yes.

MR. BOYLE: Objection.

BY MS. PAI-THOMPSON:

Q. You described the binders that you have with the reports and the exhibits. Do you have any other printed documents with you?

A. I have my deposition -- or my expert report, sorry.

Q. Perfect. Thank you. Any other documents other than those binders and your report?

A. Not right here, no.

Q. Okay. So not visible to you?

A. Correct.

Q. Great. So do you agree not to look at any documents during the deposition other than when we identify a document and are discussing it together on the record with the court reporter?

MR. BOYLE: Objection. I'll instruct you that that's not part of the rules or a requirement. And I'll instruct you that that's not -- you don't have to agree to that.

BY MS. PAI-THOMPSON:

Q. Do you agree that if you look at a document or a source of information while we are on the record that you will identify what you're looking at so that you won't be looking at anything that isn't recorded by our court reporter?

MR. BOYLE: Objection. Same objection. She'll answer questions but...

MS. PAI-THOMPSON: Sorry, I'm just looking at a note to myself.

BY MS. PAI-THOMPSON:

Q. I think that we'll follow up on this more because again, I think that we will have questions about what information you're relying on, and I may just ask you more specific questions as we go along.

So moving now to -- basically since you were last here on August 31, 2023. Do you recall the deposition that you took part in that day?

A. I do.

Q. And you recall there was a court reporter there also taking a transcript at that point?

A. Yes.

Q. Great. You recall that you were under oath and agreed to testify truthfully there as well?

A. I remember that.

Q. And that you had an opportunity to review the deposition transcript and make any corrections or address any

corrections that you may have had?

A. So I -- I didn't do that immediately afterwards, but I noted some when I was reviewing for this and I had four or five typos that -- for example, they put -- and I may have said it this way, AAPLOG versus ACOG and intertwined those once and I think -- it was minor things. I think there was an is when it should have been an isn't one time. I think there were four or five things and I don't think they got sent to you all.

Q. I would ask if at any some point I direct you to a portion of the deposition or transcript where something comes up that you have not corrected in writing already, just let me know.

A. Thank you.

Q. So other than those kind of minor, what it sounds like, typographical issues, is there anything that you want to change about the sworn testify that you gave previously?

A. No.

Q. Other than your expert report in this case, have you submitted any documents in other cases, like declarations or reports since your deposition on August 31st?

MR. BOYLE: Let me just stop and give you an instruction on that. To the extent that you have given any report such as the one you've given here that's been exchanged to an opposing side like yours was in this case, you can respond to that. But if it's just an internal report or a

conversation or correspondence with some other lawyers that have hired you as an expert witness and it hasn't been exchanged to the other side, I will instruct you not to respond and answer in the affirmative or negative for that.

THE WITNESS: Okay. So I --

BY MS. PAI-THOMPSON:

Q. Do you understand the question?

A. Well, I think I understand it. So no, I have not done any other reports. I did submit an addendum yesterday in this case.

Q. Yes. And when you refer to that, you're referring to the one-page addendum that was accompanied by some textbook pages, correct?

A. Yes.

Q. So other than that -- and again, not including any communications with attorneys, but no other documents submitted in other cases?

A. No.

Q. Have you given any testimony in other cases, either orally or in writing?

A. Since August 31st?

MR. BOYLE: Object to form.

BY MS. PAI-THOMPSON:

Q. Have you given any testimony since August 31st in other cases orally?

A. No, I have not.

Q. Have you given any testimony in other cases since August 31st in writing?

A. No.

Q. And again, these will be between August 31, 2023, your deposition that day and today, have you reviewed your report again?

A. My expert report I wrote for today?

Q. Correct.

A. I have, yes.

Q. When did you most recently review it?

A. Again this morning.

Q. Great. Have you reviewed again the sources that you cited in your report?

A. I have.

Q. Did you review every -- each of the citations that are in your report?

A. I have.

Q. And did you review them in full?

A. Yes. But I don't have them memorized.

Q. Memorization isn't expected. Just checking in about review. Have you conducted any other research since your deposition on August 31st related to this case?

A. Well, I got the textbook that I gave you the addendum, so I reviewed the textbook and, you know, my -- I have reviewed

the other individuals' declarations, their expert reports, their depositions, yeah.

Q. So for the textbook, did you review any pages of that textbook other than the ones that you sent us with your addendum?

A. I read a lot of the textbook. But there were some pieces that weren't relevant to this case so...

Q. Okay. Do you recall which portions of it you reviewed?

A. I've got the book. Do you want me to tell you the chapters?

Q. That would be great. Thank you.

A. So there's a forward that I reviewed, a preface I reviewed. Chapter one is Abortion in Historical Perspective. Chapter two is Unintended Pregnancy and Abortion and Public Health Perspective. Chapter three is Informed Consent, Counseling and Patient Preparation. Chapter four is Documenting Pregnancy and Gestational Age. Let me look at chapter five. I reviewed chapter five. Let me get back to the table of contents. Medical Evaluation and Management. I reviewed chapter six, Procedure Selection. Chapter seven, Pain Management. Chapter eight, Medical Abortion and Early Pregnancy. Chapter nine, Surgical Abortion in First Trimester. Chapter ten, Surgical Abortion After First Trimester. Let me look. I skimmed the latter chapters. Chapter 11. Chapter 11,

Abortion by Labor Induction. And I would say I skimmed the rest of the chapters. Let's see. Actually I went through the whole book, to be honest.

Q. Great. Well, thank you for going through that with us.

A. I won't say I read every single page. But I did go through the book.

Q. So is it fair to say that the pages that you sent to us are the ones that you judge most relevant to your opinions in this case?

A. I particularly wanted to -- well, I guess yes. But there were -- there are other ones. But -- I'll say yes.

Q. You say that there are other ones. The ones that you sent us are the ones that you're relying on for the purpose of supporting your opinions in this case, is that correct?

A. Yes.

MS. PAI-THOMPSON: And I am going to just drop into the chat a PDF that is -- that I'll ask to be marked as an exhibit.

BY MS. PAI-THOMPSON:

Q. We're not going to go into questions about this right now, but since it's come up I just want to confirm at this point that we're talking about the same document or excerpts?

A. Okay.

Q. And so once that has come up and you're able to open

it, if you can scroll through and let me know if that is all the pages that you believe that you sent to us or if there are any that seem to be missing.

A. I'm trying to download it because I remember on the 31st, in August when we did this, I couldn't just open them. I had to download them first. So just a second.

Q. Let me know if you would like me to screenshare, if that feels more efficient.

A. I'm going to try.

Q. And again, at this point I'm not going to be asking you about the content other than reviewing that it's all of the pages that you believe you sent to us.

A. Yeah. Okay.

(Pause.)

Q. Why don't we do this just because I know how Internet speeds go. Why don't we just put a pin in this for the moment and then you can go ahead and take that time to have that finish downloading when we take our first break, and then we'll just circle around so that we're not missing any pages.

A. Okay.

Q. So other than the materials that we have identified so far, was there anything else that you have reviewed in preparing for this case between August 31st and today?

A. I reviewed Williams Obstetrics from -- which is a mainstay textbook. I wanted to refresh myself on some basic

maternal fetal circulation. I hadn't reviewed that in a while.

Q. So Williams Obstetrics about maternal fetal circulation. Were there any other portions of that that you described -- or that you reviewed?

A. No. Just those areas.

Q. And then other than your attorney, I'm not asking about communications with counsel, have you spoken with anyone about this case since August 31, 2023?

A. No. My husband, my family. But not specifics of the case.

Q. When you say your family, other than your husband, who did you speak with?

A. I have grown children who know that I'm doing this. I have a mom who knows. I have sisters who know I'm involved in this case. I mean, so when you say spoke about, people know I'm involved in this case. My colleagues at work know. People who -- I'm on the board at AAPLOG. They know. But am I getting resources from them, answers from them? No. But they're aware that I'm involved in this case.

Q. Understood. Do they know what opinions you're providing in this case?

MR. BOYLE: Objection. You can answer.

THE WITNESS: Did you say you can answer?

MR. BOYLE: You can answer.

THE WITNESS: No, they do not.

BY MS. PAI-THOMPSON:

Q. So the fact of your participation, but not the substance it looks like?

A. Correct.

MR. BOYLE: Object to form.

BY MS. PAI-THOMPSON:

Q. Now, you described -- or referenced earlier having read reports or materials submitted by other people in this case. Did that include materials prepared by Dr. Christy Boraas?

A. Yes.

Q. And which documents -- document or documents created by Dr. Christy Boraas did you review?

A. Her original declaration, her rebuttal and her new expert report.

Q. Did you read all of the -- did you read all of the materials cited in those documents?

A. Do you mean references?

Q. Yes.

A. No, I saw what she referenced, but I did not necessarily review every single one of them.

Q. Did any of the information that you read in the -- or the citations that you saw that she had made in rebuttal, did any of those change any of the opinions that you provided either in writing or in your deposition on August 31st?

A. No.

Q. And when you reference the rebuttal, are you referring to the rebuttal report that Dr. Boris submitted in January of 2024?

A. No. I'm talking about when we initially wrote our explanation -- or our declarations last summer, she and Dr. Farris wrote rebuttals. That's the only thing I was aware of rebuttals that they had done.

Q. So you have not received a copy of a report that she prepared in January of 2024?

A. So I have read one thing, but I thought it was -- I don't know the title of it. I have read one thing since August of hers.

Q. Okay. And we can circle back to this if we need to. For Dr. Katherine Farris, can you list for us the documents that you have read that she prepared as well?

A. Her original declaration and her rebuttal to our original declarations and then her expert report this time.

Q. And when you say this time, can you tell us what month you're referring to?

A. It would have been December -- November, December of 2023.

Q. Thank you. Did you read all of the references that were cited in that document?

A. I noted them all, but I can't tell you yes or no that

I read every one of them.

Q. And same question for the declaration that she provided. I know that you hadn't read all of them at your initial deposition on August 31st. Have you read all of her references in that initial declaration since then?

A. I have reviewed them, but I have not read them all.

Q. Has any of the information from either her reports or your review of the records change any of the opinions that you have provided in this case?

A. No.

Q. Have you read written materials provided by Dr. Timothy Johnson?

A. I don't recall that I have.

Q. Okay. So you don't recall having been provided an expert report from Dr. Johnson in January of 2024, is that correct?

A. That's correct.

Q. How many hours would you say that you have spent preparing your expert report at this point?

A. Just my expert report?

Q. Uh-huh.

A. Probably 30.

Q. And how many hours would you say that you have spent preparing for your deposition today and -- so again, between August 31st and today, how many hours would you estimate you

have spent preparing for deposition?

A. So I really didn't start preparing for deposition until I knew the date, which I didn't find out maybe a month or so -- no, I can't remember when I found out. Maybe -- yeah, I think it was early January maybe. So I would say around 20 hours or so.

Q. Okay. And then other than the time that's been captured by the 30 or so hours that you spent preparing your expert report and the 20 or so hours spent preparing for the deposition, have you spent any other time working on this case which haven't captured through those questions?

A. No.

Q. And you're being paid $500 per hour for your work in this case. Is that still correct?

A. Yes.

Q. I'm switching gears just a bit.

A. Okay.

Q. Did you attend the March for Life in Washington D.C. on January 19th of this year?

A. I did.

Q. And did you attend any other events while you were in D.C.?

MR. BOYLE: Object to form.

THE WITNESS: Yes.

BY MS. PAI-THOMPSON:

Q. Did you attend any other events in Washington D.C. while you were there for the March for Life?

MR. BOYLE: Object to form.

MS. PAI-THOMPSON: And you can answer the question.

THE WITNESS: Okay. Yes, I did.

BY MS. PAI-THOMPSON:

Q. What events did you attend?

A. So I attended a reception at Heritage Foundation for AAPLOG and I actually spoke there. Sorry, it was a busy week. I attended a reception at ADF and I had some internal meetings that weren't events. Some dinners, but they weren't events. Those are the main things. And of course the march is all day long.

Q. For the -- you said that you spoke at the AAPLOG reception. What was your talk about?

A. Having courage to basically stand for what you believe and fight for -- as a doctor that practices life-affirming medicine, to stand for both my maternal and fetal patient. The theme of this year's march was with every woman -- for every woman with every child or vice versa. So talked about that. I talked about the past, present and future of medicine in our field. My talk was maybe three to five minutes. So it was extremely brief about what I think about the history of our field, what the present and then future of our field.

Q. When you talk about the history of our field, can you -- or your field, can you tell me what the kind of -- give me the gist of that.

A. Yeah. So I talked a lot about ACOG and AAPLOG's relationship and how we really work together well. We were included in ACOG cog for years. And when I say we, I mean physicians who had a pro-life perspective and -- which is a lot of us. As you know, you know, from all the depositions and the reports that there's a minority of physicians that actually do induced abortions. And that which actually -- we had collaboration. And unfortunately that's gone away. And that we were part of a very large special interest group in ACOG for years. ACOG special interest groups of all types and there was a pro-life one. And in 2013, unfortunately ACOG got rid of all their special interest groups. And so we had -- we formed our own organization. Even though we had the organization, we were within ACOG as the special interest group. But we're no longer welcome there. And that -- so now we're a second voice, second medical organization that takes a life-affirming approach. So that was historically what I shared.

Q. Thank you. Did you discuss your involvement in this case at any of the meetings or dinners that you -- I think you mentioned receptions that you attended?

A. I did not.

Q. Who paid for your travel to Washington D.C.?

A. I did.

Q. So I know that you have your copy of your expert report. I'm going to drop it into the chat as well so that we can -- and ask that it be marked as an exhibit for the purpose of this deposition. And I'm dropping in what you provided to us. So your expert report that includes your C.V. as well.

- - -

(Document marked as Exhibit-25 for identification.)

- - -

BY MS. PAI-THOMPSON:

Q. Are you able to see that?

A. I am going to try a different way this time. See if I can get it.

Q. We can also note, we sent to Mr. Boyle this morning the PDF that we would be using for exhibits today. So if a copy that you have, that you showed printed in front of you is printed from that version that he provided you, you can also look at that.

A. So it's not the one from today. I mean, it's my final report that I, you know, gave. But it's not based on your list. But what I can do is easily pull up your list and compare them, because I think your list is easy to pull up.

Q. And since we're talking about your report that's been produced to us through discovery, and I think we're talking

about the same document, we'll go ahead and just like with the other -- go through some of it you can reference the paper copy that you have and then we're getting pretty close to where we'll take our first break, and you can follow up with the downloads at that point.

A. That will be fine.

Q. It's going to jump around just a little bit, just so that you know, because we're endeavoring not to repeat information that you have already gone over in your initial deposition. So if that creates confusion at any point, please let me know and I'll be sure to clarify.

A. Thank you.

Q. Of course. Directing your training during medical school, you never provided an induced abortion during medical school, correct?

A. Correct.

Q. And you never provided an induced abortion during your residency, correct?

A. I'm going to say correct, but I want to make sure that we put on the record that we're agreeing on what induced abortion is, right? So the definition when I say correct is the CDC's definition, which is an intervention designed to intervene for a suspected or ongoing pregnancy with the intention of not having a live birth. So the purpose of the intervention is to end the life of the fetus or the embryo. So

produce a dead baby. I never have done either of those.

Q. And for our reference, you have defined those terms, and then also some other terms related to abortion in your initial deposition on August 31st. So I will -- we can have a common understanding that we are using those definitions that you gave. If at some point you feel like you need to redefine or clarify one of them, that's fine. But thank you for highlighting that and I'll just note that those definitions that you gave will stand.

A. Thank you.

Q. Absolutely. Now that we have talked, I'm missing -- want to make sure that we got an answer to a question. So you did not provide an induced abortion based on that definition you gave us during residency, correct?

A. Correct.

Q. And you did not provide an induced abortion during your time as a practicing physician, correct?

A. Correct.

Q. And just as a brief clarification on the induced abortion definition, just again to ensure that we're talking about -- we're using shared terms. Just to be clear, you would not include an induction abortion before viability with the intent to separate the fetus from the patient's body in the definition of induced abortion, is that right?

A. That is correct. I did those procedures, but my

intention was to try to save both knowing that some times the unintended consequence is that the fetal patient doesn't survive.

Q. Okay. But just to be clear, that -- actually I'm going to withdraw that question. So you also taught at Barton College from 20 -- you also taught at Barton College, correct?

A. Yes.

Q. That was beginning in 2010?

A. Part time and full time in 2011.

Q. Correct. And you taught there through 2023, is that correct?

A. Correct.

Q. Have you ever taught any courses involving induced abortion?

A. So -- not at Barton College. So I did teach a class that was actually -- okay. So I'm going to correct that last answer. So I taught a gen 301 class. I think it was gen 301 back then. It might have been gen 300. It's called the Capstone course in the humanities in the general education curriculum where students put together critical thinking, oral thinking, writing. So actually I did teach a class. When you asked the question, I'm sorry, I was thinking medical -- not Barton. So yeah, I actually did teach one class.

Q. And just so that we're clear, when you say gen 301, you mean general, that's referring to the general education

requirement?

A. So at Barton College we have a general education curriculum and then we have a major specific curriculum. Students take both. And the Capstone course in the general education curriculum is called gen. And so students all across campus could take that and I had a variety of students in that class.

Q. I think that if -- well, no, we still have time. Sorry, I'm trying to be mindful of the clock because I'm someone who can just roll on through and I don't want to do that to you.

So I'm going to refer to your report, if you can pull your copy of that and to paragraph 68 of your report. And just let me know when you're there.

A. I'm here.

Q. Perfect. Thank you. So I'm going to read a passage of this to you and then I'll ask you whether I have read it correctly. And feel free to let me know if I have missed a word or gotten any incorrect.

A. Before you do, my phone just went off. So let me look at something real quick. Okay. It's not my son.

Q. Great. Thank you. And thank you for letting us know.

A. You're welcome.

Q. So in your report in paragraph 68, you say in quotes, as I have examined the literature related to very early

abortions, I agree with some authors that state diagnosing an ectopic pregnancy as early as possible is a benefit of these protocols.

Did I read that accurately?

A. You did.

Q. And you agree with your statement in your report there in paragraph 68 that, quote, diagnosing an ectopic pregnancy as early as possible is a benefit of those protocols, correct?

A. I agree that diagnosing an ectopic pregnancy is beneficial for any woman. Where I disagree is that it justifies doing an abortion without a documented IUP.

Q. Thank you. So by these protocols that you're -- that reference in paragraph 68, you're referring to the medication abortion protocols for pregnancies of unknown location, is that correct?

A. Yes.

Q. Okay.

MS. PAI-THOMPSON: So I am going to drop another document into the chat and I will ask that this be marked as an exhibit. And this again you should have received in the documents that we provided to Mr. Boyle earlier today. This is a statement from ASA. It's a statement from ASA on the continuum of levels of sedation.

- - -

(Document marked as Exhibit-26 for

identification.)

- - -

BY MS. PAI-THOMPSON:

Q. Do you have the document that I'm referring to?

A. Yes, I do.

Q. And have you read this document before?

A. Well, I need to look at the one I referenced to make sure -- it doesn't seem like this first page is the same as my first page.

Q. Okay.

A. Do you know the number of my reference for the ASA? If not, I can look. Let's see.

(Pause.)

A. I'm going to just pull up my hard copy that I have.

Q. And we're at footnote 45 in your report, if that's helpful.

A. I found that. Thank you.

Q. Yeah. Absolutely.

A. So mine starts with statement on granting privileges for administration of moderate sedation to practitioners who are not anesthesia professionals. That's page one of mine.

Q. All right. I think that we have -- so let's do this. Can you -- the document that I dropped in the chat is short. Can you take a moment to review the first two pages of that document and I will -- the questions I have I think will be --

basic enough that given your expertise we'll be fine moving forward. But let me know if after I have asked the question you feel like you need more time.

A. Okay.

(Pause.)

Q. So looking at the document that I moved into the chat, just clarifying for us non-doctors in the room. By spontaneous ventilation there, that would be referring to breathing, is that correct?

A. Could I have a minute just to look at the document?

Q. Oh, absolutely. I'm sorry. When you said okay, I thought you meant okay, proceed.

A. No. Give me just a second.

Q. Absolutely.

(Pause.)

Q. So let's actually, Dr. Bane, just given our time and to get us to our first break, I'm actually going to do this. I'm going to ask you some questions about sedation and we'll just do this just independent of the document. Just based upon your knowledge and expertise. Is that okay?

A. That's fine. But I was almost done if you want to refer to the document.

Q. Yeah. Sure. Then go for it.

A. Okay.

(Pause.)

A. Okay. You can reference it now.

Q. Okay. Thank you. Do you agree with the description of the levels of sedation that are provided in that document?

MR. BOYLE: Objection. You can answer.

THE WITNESS: Could you repeat the question?

BY MS. PAI-THOMPSON:

Q. Yes. Do you agree with the description of the levels of sedation provided in that document?

MR. BOYLE: Objection. You can answer.

THE WITNESS: Yes.

BY MS. PAI-THOMPSON:

Q. Thank you. Do you know what kind of sedation options are available at Planned Parenthood South Atlantic?

A. Based on the protocols I reviewed, they have documentation that you can opt for everything except general anesthesia. However, I believe it was Dr. Farris's deposition that she stated that they don't actually offer deep sedation, even though that is an option on their form.

Q. So your understanding is that Planned Parenthood South Atlantic offers minimal and moderate sedation, but not deep sedation? Have I summarized that correctly?

A. That is my recollection of reviewing everything.

Q. Great. And for minimal sedation, a patient is conscious throughout the sedation, is that correct?

A. Conscious, yes, but sometimes asleep.

Q. But they can be roused by verbal or physical stimuli?

A. Typically, yes.

Q. And same question for moderate sedation, that a patient is typically conscious during the sedation, and by that I mean the sedation doesn't render them unconscious?

A. Correct. Typically. Everybody responds differently, and that's the biggest concern is what you think is moderate sedation can move to deep, what you think is moderate can lead to someone being unarousable and that's the biggest concern with sedation.

Q. And you reference that can lead to a patient being unarousable. At the point that a patient was unarousable, the provider would know that they were no longer in minimal or moderate sedation, correct?

MR. BOYLE: Objection.

THE WITNESS: I would sure hope so. There's no information from the protocols that there is somebody different than the person doing the induced abortion, the surgical abortion that's separately monitoring the person. So I think there is concern that they may not recognize if they have moved into a level of deeper sedation. And I think that's consistent with the document that I provided that that's a major concern of the American Society of Anesthesiologists.

BY MS. PAI-THOMPSON:

Q. And that's because of your understanding that there --

withdrawn. That was going to be a confusing question, so I'm going to ask it differently. What I hear you expressing there is that if there wasn't another person in the room other than the provider, they might be focused on the procedure and not notice. Is that a fair summary?

MR. BOYLE: Objection.

THE WITNESS: I think that's one element of it if they're responsible for both of those. So when I'm in the operating room I'm focused on doing my surgery and I'm trusting the anesthesia professional to monitor all the various things, responsiveness, airway, cardiovascular system, spontaneous ventilation. So I am -- I don't understand that that is happening based on the protocols that I have seen at Planned Parenthood. Also recognizing that I have no idea all the other protocols that are happening across the state knowing that, you know, only about 30 percent of the surgical abortions are happening -- abortions are happening at the Planned Parenthood. We have many other facilities that are happening. And so I'm very concerned based on what the American Society of Anesthesiologists -- they talk about individuals who are not professionals having the adequate level of training to be able to recognize that somebody is -- you know, got normal cardiovascular function, they're spontaneously breathing. So that's my concern.

BY MS. PAI-THOMPSON:

Q. Is it your opinion that only an anesthesiologist or a nurse anesthetist would be qualified to provide or supervise moderate sedation?

MR. BOYLE: Objection.

THE WITNESS: My opinion is consistent with what the American Society of Anesthesiologists suggests is that it takes special training and education. In their document that I cited, they talk about non-anesthesiologist sedation practitioners and the special training they get. And I don't have evidence that that is occurring across the State of North Carolina in our abortion clinics.

BY MS. PAI-THOMPSON:

Q. So is it your opinion that no one else is qualified to provide or supervise moderate sedation other than anesthesiologists or people who are receiving that special training that you just referred to?

MR. BOYLE: Objection. You can answer.

THE WITNESS: So I'll reference -- I'm sorry, but it doesn't have page numbers. But under section one, non-anesthesiologist sedation practitioners. It says here that non-anesthesiologist sedation practitioners may directly supervise patient monitoring in the administration of sedatives -- sedative and analgesic medications by a supervised sedation professional. Alternatively, a person may perform these functions with the provision that the individual monitoring the

patient should be distinct from the individual monitoring the diagnostic and therapeutic procedures. Single operator sedation should not be permitted and is deemed unsafe.

So I follow their recommendations because they're the experts in anesthesiology and sedation.

BY MS. PAI-THOMPSON:

Q. And just one clarification in the paragraph that you just read. I think -- at least what is in my printout, the third line from the top of that paragraph, I think that you said should be distinct from the individual monitoring the diagnostic or therapeutic procedure. Does the document actually say the individual performing the diagnostic or therapeutic procedure?

A. I'm sorry, which line are you referencing?

Q. On my printout -- let's do it this way. It is the second to last sentence. Just before see practice guidelines for moderate procedural sedation.

A. Alternatively, they may personally perform these functions with the provision that the individual monitoring the patient should be distinct from the individual performing the diagnostic or therapeutic procedure.

Q. Can you tell me, what date is the last amended date on the version that you have?

A. 2021.

Q. October 13, 2021?

A. Mine actually says October 12, 2021.

Q. Okay. Thank you. And we are almost at our break point, so I'll give you that. So is your opinion based upon anything other than what is in this ASA document that we just talked about?

MR. BOYLE: Object to form.

THE WITNESS: Could you repeat that?

MS. PAI-THOMPSON: Yes. Absolutely.

BY MS. PAI-THOMPSON:

Q. I'm referring back to your testimony that a person should be an anesthesiologist or should have the training that's referenced in this ASA document in order to provided moderate sedation?

A. So my opinion is --

MR. BOYLE: Object to form. You can answer.

THE WITNESS: Okay. So my opinion follows what this document says as it relates to the safety of a patient. This document doesn't address pain management in a patient and that's also a concern for me that we -- it's hard to believe we would accept a level of pain that women describe that for abortions that we would not accept for other procedures, all in the name of doing it in an outpatient setting. And so I do -- -- I do want patients to not -- I want to control their pain as much as possible, their physical pain, in the case of anesthesia.

BY MS. PAI-THOMPSON:

Q. Thank you. Referring to the comments that you just made. Do you think this is a result of abortion patients being treated less well than patients seeking other obstetric or gynecological care?

A. I think sometimes we get -- I think there is such a desire for everything to be done in an abortion clinic, in an outpatient setting that sometimes that overrides the thought that we can more safely provide better, deeper sedation for a second trimester abortion. Even a first trimester abortion can be very painful. So I do think sometimes, yeah, abortion is treated differently by the people who are providing the abortions.

Q. So is it your opinion that it would be safer to provide deep sedation to every patient obtaining a second trimester abortion?

A. No, that's not what I'm saying.

Q. Are you -- do you -- is it your opinion that it would be better from a pain management perspective?

MR. BOYLE: Object to form.

THE WITNESS: So I think you're going to -- you'll have a conversation with a woman to talk about her options and her preference. Some patients over my 20-plus years of practicing will walk in and say there is no way I'm getting "X" procedure done unless I am asleep. And there are

other people who want more minimum sedation. So I do think you can't -- it's a hypothetical to try to say for everyone. But I think we have to be careful that we don't sacrifice and hurt women all in the name of trying to stay out of the hospital.

BY MS. PAI-THOMPSON:

Q. Thank you. So for the safety piece, is there anything that you are basing your opinion on other than the ASA guidelines that you have referenced? And by that I mean experience, other papers, things like that.

A. So I have only documented in my expert report this. But from an -- from a 20-plus year experience doing thousands of surgeries, absolutely. My experience definitely tells me that I can concentrate more on the job that I'm responsible for if I know that there's a competent person who's making sure my patient stays alive. And so, you know, that most definitely influences it. And I do care about pain management. So it would be a combination of experts like the American Society of Anesthesiologists, as well as anecdotal experience as an obstetrician/gynecologist.

Q. Sorry, I don't mean to cut off.

A. I just said obstetrician/gynecologist.

Q. Yes. So you reference experts like ASA. Are there other sources or other associations whose opinions you're relying on for your opinion here?

A. This is the main society that I relied on and so I'll

have to say just them in terms of a professional organization. And there are studies out there also that look at, you know, pain control, but I chose not to cite them. I chose to site more of -- kind of like with ACOG, practice bulletins or committee opinions. A conglomeration of the sites -- of the studies that lead to a statement.

Q. Okay. And then just a couple more quick questions before we'll take our first break. So looking at general anesthesia itself. Does general anesthesia alone carry medical risks? And by alone I mean risks that are separate from whatever the risks are of the procedure that the general anesthesia is connected to.

A. All sedation carries risks.

Q. So with respect to general anesthesia, what kind of risks does it carry?

A. Well, for that one, you're actually intubating someone and so, you know, there's a risk of intubation in terms of not being properly intubated or actually tearing, for example, the esophagus when someone is intubated or something like that. So there's that risk. There's risks -- pregnant women have risk for -- greater risk for aspiration than do other women that are not pregnant. You're taking someone and you're putting them in such a deep sedation, there are some people that take a while to come out of that and I have even had patients who have had to stay intubated. So yes, there are risks.

Q. Thank you. When you say that there are risks that a patient might not be properly intubated, what risks does that create?

A. Well, if you think you're in the trachea and you're actually in the esophagus the person is not going to be getting adequate oxygenation and could have cardiovascular collapse, stroke, a heart attack. So you have to properly intubate someone. And then in terms of the -- it's a metal instrument that people use to intubate so you can actually have tears. It can cause bleeding. So those are the main things.

MR. BOYLE: We have been going for about an hour if you're at a spot where you might take a break.

MS. PAI-THOMPSON: Yeah. I just have two quick follow-up questions on Dr. Bane's comments about the risks and then we are at a perfect point for a break. Thank you.

BY MS. PAI-THOMPSON:

Q. So Dr. Bane, you mentioned that with some patients they stay in deep sedation, like they have a tougher time coming out and may have to remain intubated. What are the kind of risks that go along with remaining intubated?

A. The biggest one is that you never get extubated, you know. And so that can lead to death. It can lead to aspiration pneumonias. All the things that go with a long term intubation. You may have to get a trachea -- it often is a sign of some underlying neuromuscular condition -- other

conditions besides neuromuscular. But often if breathing doesn't come back. You know, I have seen it and then a patient gets diagnosed with myasthenia gravis or ALS or something like that. So it's uncommon, but it can happen. The majority of people do just fine, but there are risks with general anesthesia.

Q. Thank you. And then my final question before our break. For pregnant women you said that there is increased risk of aspiration. Can you describe what aspiration means, what that is, kind of how that looks?

A. Sure. So, you know, if you have ever had surgery, you have been told don't eat anything after midnight, maybe you can drink some water, brush your teeth the next day. So you basically don't want food in the stomach because when you have general anesthesia it can relax the sphincters, and there's an esophageal sphincter between the stomach and the esophagus, which is the tube that goes to the stomach after you swallow. And so if food gets refluxed back or contents of the stomach and get into the lungs, that can lead to infection.

Q. Are there any other risks beyond infection of aspiration?

A. I'm sure there are, but not that I can recall right now.

Q. Perfect. And I'm sorry that I promised one question and there were two, but I do think this is a good time to take

our first break. Should we say -- does 10 minutes feel like enough?

THE WITNESS: Sure.

MR. BOYLE: Sure.

MS. PAI-THOMPSON: And then for our court reporter, when we come back I'll ask just for a time check.

MR. BOYLE: I have got one hour and seven minutes.

MS. PAI-THOMPSON: Great. Thank you. We'll see everyone in 10.

- - -

(A break was taken, 2:44 p.m. - 3:00 p.m.)

- - -

BY MS. PAI-THOMPSON:

Q. So Dr. Bane, I'm going to be talking more about your expert report. So just in terms of what you have in front of you. And I'll be looking at paragraph 56, but referring back to our earlier discussion about just ensuring that we have -- that we're using the same definitions so we have common understand. Just kind of a preference question for that. So can you tell us -- or just describe to us how you would define a missed abortion?

A. Yes. So a missed abortion is when a woman is asymptomatic, so she doesn't have any bleeding or cramping, and typically we're doing an ultrasound for dating and we don't see

a heartbeat.

Q. Thank you. So in paragraph 56 of your expert report, you identify some things that can happen when an embryo or fetus has no cardiac activity and the pregnant person's body is physiologically preparing to expel it. Do you see the section that I'm referring to?

A. Yes, I do.

Q. Perfect. And is what you're describing there what can happen with a missed abortion, as you just defined it?

A. Would you clarify the question? I'm sorry.

Q. Sure. So in paragraph 56 where you are talking about -- these will just be examples. We'll go back -- that -- sorry. Let me just actually -- I'm going to look in my note and see that I have not -- I can't just more easily ask the question in a different way. Let's actually -- I'm going to withdraw the question that I had and move to another question and we may circle back, but you can tell me if you feel like we missed something given that.

So I would like to talk about some of the things that you identify can be happening physiologically in a pregnant person's body when they are preparing to expel an embryo or fetus with no cardiac activity. You described in your report that the cervix may already be softening and partially open, is that accurate?

A. Yes. I state the cervix may already be softening and

partially opening. It's not always the case, but it can be. I have operated on women to do a D&C and they -- I go to do my exam and I can already put my finger in. Now those are not women typically with a missed abortion. Those are women that usually have symptoms in terms of their cervix making those changes because they'll often start spotting if their cervix is starting to open.

Q. And so if they -- just again so we're using the same terminology. How would you define a situation or what term would you use for that, where they are having some symptoms such as spotting?

A. So if they don't -- if they're having those symptoms and they are -- and we have diagnosed the embryo or fetus has died then they -- if they're already partially open, the cervix, then they would -- particularly if you can see any of the products of conception, whether it's the embryo, fetus, or the extra, the placenta, other tissue that's not the actually embryo or fetus, you can sometimes see them at the opening. So that would be an incomplete abortion. So she's in the middle of miscarrying.

Q. And I appreciate the juxtaposition there. So you said that not all patients have this softening and partially open. Does that mean that some would have cervixes that are what you describe as closed and thick?

A. Yes. For the cervix, yes.

Q. Thank you. So same paragraph of your report, in paragraph 56, you say that most women will naturally expel the pregnancy within two weeks and thus expected management is an option given to them. Is that an accurate summary of what's there?

A. Yes, it is an accurate summary.

Q. And are there some miscarriages or miscarriage patients who don't naturally expel the embryo or fetus within two weeks?

A. There are. The data suggests that 80 percent of women will miscarry within two weeks --

Q. I'm sorry.

A. -- on their own.

Q. On their own. Thank you. Is there anything other than those two things that we just talked about? Is there anything else about the state of the pregnant person's body that is maybe different?

A. Between what? Sorry.

Q. No. No. Absolutely. So with the situation where there is no longer embryonic or fetal cardiac activity, you say that the body is preparing to expel the pregnancy, other than the cervical changes and the sort of time frame that we just discussed, are there other physiological changes that you see?

A. Oh, most definitely. So the woman will often times say that she no longer has breast tenderness, she's not tired

like she was. And that is related to a drop in hormonal function. So she's no longer feeling the symptoms of pregnancy. And she may start cramping, which is the uterus preparing to expel the embryo or the fetus. You know, I think from the standpoint of when you deliver or you examine -- so let me back up. So, you know, when a woman is in her first trimester and has had a miscarriage, we will offer her expectant management, medication management, or surgical management. And every woman, you know, there are different conversations that you have with the women regarding that. But when I have done surgical or we do -- if she's a little further along, second trimester, induction, the biggest change you see is actually in the embryo or the fetus because they have lost their blood supply. And so just like if you and I lose our blood supply, our cells, our tissues die and we decompose, so do these embryos and fetuses. And so, you know, that's the other big thing that you see in our second patient is that going on.

Q. Okay. Any other physiological changes in the pregnant patient?

A. So we have talked about bleeding. She may be -- maybe we haven't talked about bleeding.

Q. Okay.

A. You know, I mentioned it, yeah. So bleeding and cramping are the biggest things. Loss of her pregnancy

symptoms. And then her cervix may start to open on its own. And then the fact that the baby or -- the embryo, the fetus is basically decomposing, autolyzing, maceration, I think, are terms that we use tells us that the physiology of blood flow is changing internally. We can't see that on the outside, but the evidence, the fact that she has a reduction of blood flow now going to the baby is evidenced by what we see in the baby. And there are studies, for example, that show like placental atrophy in women who have had a pregnancy loss in the second trimester and the placenta actually gets smaller. They do expectant management for a little while and they notice the volume of the placenta by ultrasound is smaller. I can't see those externally, of course.

Q. Thank you. So I'm focused now on some questions that deal with gestational age.

A. Okay.

Q. We'll be jumping around some so we're not repeating. Are you aware of any published medical research discussing the comparative safety of procedural miscarriage management and procedural induced abortion at the same gestational age?

A. Using the term procedural, are you also -- I know there's a lot of conversation about surgery versus procedure. So could you say that question and replace it with surgical also?

Q. Absolutely. So are you aware of any published medical

research discussing the comparative safety of surgical miscarriage management and surgical induced abortion at the same gestational age?

A. Surgical miscarriage compared to surgical induced abortion?

Q. Correct. At the same gestational age.

A. I am not aware of any direct studies that compare those.

Q. Thank you. Are you aware of any books or other publications that compare those?

A. I'm aware of a lot of conversation that happens in labor and delivery, in operating rooms, among colleagues anecdotally about differences that people describe. I'm aware of in textbooks conversations about the technical difficulty of an induced abortion compared to a miscarriage, particularly because on a miscarriage you already have a dead fetus if it's second trimester and you have a live one with the first one, and of course you'll have the bony structures that make for a more technically difficult procedure. And that's supported in the addendum information I gave yesterday about, you know, within 16, I think, to 24 hours the bones, the cortical bones soften. And I'm aware that the bones, removing them, particularly the skull are -- the calvarium, which is the skull, is where a lot of the cervical injury and hemorrhage can come from. That's what I'm aware of.

Q. Thank you. And I think that this is clear, but I just want to make sure that I know that it is. The textbook that you just referred to and you mentioned the addendum, that's those excerpted pages that you sent over to us and the textbook we talked about earlier, correct?

A. Correct.

Q. Any others?

A. Not off the top of my head.

Q. Okay. Thank you. And you describe the written sources and then also anecdotal kind of accounts from other people. You talk about -- you don't have personal experience with this, with induced abortions since you haven't performed them, correct?

A. So I have a lot of personal experience with labor inductions where we have second trimester either -- fetal demises or I had to do previable inductions. And the difference in terms of when there has been a loss, so the fetus is dead, those babies come out and sometimes their skin is sloughed off. They have macerated and their -- you can tell their bones are soft. They're kind of bent and their skulls collapse. So I do have that experience. I don't have the experience of a D&E extraction where I am removing the dead fetus or living fetus.

Q. And as you said, just to clarify, so no experience with D&E to provide an induced abortion as you have defined

that earlier, correct?

A. Correct.

Q. Thank you. So I'm going to turn now actually to the textbook pages.

A. Can I pause you real quickly? So my son is home. I'm going to turn -- my phone is going crazy. I'm going to silence it real quick. But he's home and my husband is here so I don't have to worry about my phone.

Q. Thank you. I appreciate you letting us know and I'm glad that he's home.

A. Thank you.

Q. Again, I'm turning now to the supplement and then the textbook pages. And since we're having the download issues, my plan is I will refer to some of the textbook pages. I'm not going to refer to all of them. If for some reason my reference makes you think there's an issue with what we have, please let me know. But other than that, we'll just --

A. And I have the book right here.

Q. We'll act on our good faith that we have -- everything that you think you gave us you did, and you can always follow up with us and we'll ask that Mr. Boyle does if you realize that there's anything you thought you provided that we didn't receive.

A. Okay.

Q. So based upon the passages that you cited in the

supplemental source, so that supplement that you gave us, would you agree that your training in miscarriage management does not qualify you to provide induced abortion by aspiration or D&E?

A. That's a loaded question. Say that again.

Q. Absolutely. So based upon the passages that you have cited -- and I'm just flipping here myself because I should have flipped earlier -- so based upon the passages that you have cited in the addendum -- and so just for reference those are the passages at pages 111, 131 and 158.

A. Okay.

Q. So then the follow-up -- and just also flagging that it's page 111 that refers specifically to training, but I want to kind of key us into the different passages that we're dealing with.

A. Okay.

Q. So based upon those passages at page 111.

A. Okay.

Q. And I'm going to just read from the addendum you were provided, the passage that's there, which is, quote, although abortion is among the most common medical needs of women, fewer than half of graduating obstetrics, gynecology residents in the United States have ever performed a first trimester induced abortion. And then the second section -- or second sentence you have bolded in the addendum. Training and the management of incomplete spontaneous abortion is not an adequate

substitute. So that's the passage that I'm referring to with this question.

A. Okay.

Q. The question is would you agree that your training in miscarriage management does not qualify you to provide induced abortion by aspiration or D&E?

A. Would you define qualify me?

Q. Well -- sorry, I'm just looking back to the wording. Okay. So I'm focusing on the training and the management of incomplete spontaneous abortion is not an adequate substitute. So would you agree that your training in incomplete spontaneous abortion is not an adequate substitute for specific training in providing induced abortion by aspiration or D&E?

A. That's a long sentence. Can you simplify what you're asking me?

Q. Yes. I will break it out into a few questions. You have training in the management of incomplete and spontaneous abortions, correct?

A. Correct. Among other things that I'm trained to do, yes.

Q. For the purpose of this question. And you have stated the opinion that -- or highlighted this passage for us that talks about an absence of, quote -- well, I'm going to change perform to performing. Performing a first trimester induced abortion as part of an obstetric, gynecological resident's

training, correct?

A. Right. That's what it says, yes.

Q. And in providing this in the addendum, you are providing it to support the position that management of incomplete spontaneous abortion isn't a substitute for that experience performing a first trimester induced abortion in residency, correct?

A. I think that's simplifying it. So I am providing it to highlight the fact that they're not identical procedures. And so my operative note may say that my procedure was a D&C, but in all -- or a D&E for that matter. But in all reality, each procedure is technically very different. And there's a big difference between doing a D&E in the second trimester for a dead fetus or a live fetus. And that it is recognized in our field that they are so different that not only do you need to go to four years of training to be an ob-gyn and all the things we do, that you need additional training if you're going to do them and be a complex family planning fellow and get two more years on top of four years. So I am not a trained complex family planning fellow. I have not done that program. And so I don't have that training. That's my point.

Q. Okay. Thank you. And again, just following up, you also haven't performed a first trimester induced abortion as it's referred to in the passage on page 111, correct?

A. All D&Cs I have done in the first trimester, the

embryos had -- fetuses had a heartbeat. Or didn't have a heart beat. Sorry.

Q. Thank you.

MS. PAI-THOMPSON: And I am going to, just so I don't forget, I am going to drop into the chat and ask to have marked as an exhibit the addendum first and then the textbook pages second. And again, that's for our record, but you and I will see it on paper copies given the Internet.

- - -

(Documents marked as Exhibit-27 and Exhibit-28 for identification.)

- - -

BY MS. PAI-THOMPSON:

Q. Do you agree that you're not qualified to provide an induced abortion?

A. No, I don't agree necessarily with that statement as simply as it is and as flat as it is. Because of the extensive training that I have had as an ob-gyn I have a lot of skills, and if I had to do one, I could -- I could work my way through it probably. But I think the complication rate -- I'm not as experienced as somebody who has done them for 20 years or who has done a complex family training fellowship. Which is why I think we have to be really careful about who's doing our second trimester abortions here in North Carolina. So I don't think it's a black and white question the way you asked it.

Q. I appreciate the followup. And what I'm hearing you say is that a provider's experience, right, like their level of experience in providing a procedure is important to the safety of that procedure? Is that what you're saying?

A. I think there's formal training, and obstetricians and gynecologists, we are trained as surgeons. And so I think that in itself is very different than, for example, Dr. Farris who is a trained family practitioner who is doing second trimester abortions here in North Carolina based on informal training she's received from people in the office, per her deposition. And so I think we're very different in that respect. So I think it's very hard to categorize me as not qualified.

Q. Thank you. Are you aware -- well, actually, let me back up. I'm sorry. Do you know what -- and this is a mouthful for me as not a doctor, what disseminated intravascular coagulation or DIC is?

A. I do.

Q. Can you define that for us?

A. Yeah. It's a situation that's often secondary to hemorrhage in which -- so a lot of people just think our blood is -- I'm not sure what people think. But it's mainly water. But it's made up of red blood cells too, but it also has clotting factors in it. And so when somebody hemorrhages they will often deplete their clotting factors. So they then don't clot and throughout their entire body they can have

disseminated, which means throughout the entire body, intravascular coagulation problems.

Q. And can you -- when you say problems, can you say more about what problems looks like in that context?

A. They can bleed to death. I mean, they literally will die if you can't help them clot their blood. And so you replace -- when someone is having a hemorrhage, whether it's postpartum or after an abortion, car accident, whatever, you have to not just give them red blood cells in volume, you also have to replace clotting factors.

Q. Thank you. Are you aware of research demonstrating that the risk of -- actually, let me back up. Is it okay if I refer to disseminated intravascular coagulation as DIC so I don't have to keep saying the words?

A. Yeah.

Q. Thank you. Are you aware of research demonstrating that the risk of DIC as a complication of D&E increases as the time since fetal demise increases?

A. Yes, I am aware of that, particularly in IUFDs after 20 weeks.

Q. Just when you say IUFDs after --

A. Intrauterine fetal demises. So, yeah.

Q. Would you agree that the risk for D&E for miscarriage management can be higher than the risk of D&E for induced abortion at the same gestational age?

A. I'm sorry, repeat that.

Q. Yeah. Would you agree that the risk of D&E for miscarriage management can be higher than the risk of D&E for induced abortion at the same gestational age?

A. I have to answer that anecdotally. We don't have head-to-head data. And, you know, women all present very differently. So a woman who has had a loss, so her baby is dead, the longer she goes without it being known, she does have that risk for DIC, as you said. It's extremely uncommon though. I have seen it a couple times, but it's very uncommon. Whereas when you have an induced abortion it's very, very different physiology that's going on when you have in a woman's body and the blood flow. So, you know, the -- the aorta is the biggest artery in our body and it has these two vessels that come out in our groin. They're called our internal iliac arteries. And then our uterine arteries come off of those. They're branches. And they come off right at the cervix and they travel kind of up the sides and they are huge as a term, for sure, especially in C-section. But the bigger the uterus -- the uterus starts off awful small. It's like a lemon or orange. It depends. And then it gets basketball size at term. And so as it grows, the demand for blood flow is greater. And so that demand when you have a live baby is still in place. That demand goes away when the baby dies, which is why we see the maceration and things like that. As a matter of fact, the

blood flow is so brisk in a living baby, it's like 500 cc a minute. That's like a half Coke bottle, a big liter bottle in a minute. And that changes when we have a baby that has already died. And so, you know, when you look at risk of bleeding and hemorrhage just anecdotally, it's a very different system. I think the other thing I would add is that -- and I mentioned this before is a lot of the risk for hemorrhage comes from -- and I think Dr. Boraas said this in her deposition. You know, when she teaches residents, you know, having to be very careful about removing the fetal parts that have bones because they're what tear that cervix. And that uterine artery is juicy. It's big. It's right there. So, you know, when you're doing a second trimester induced abortion compared to -- with a dead baby the blood flow is going to be different.

Q. Thank you. So going to be turning now to the textbook pages.

A. Okay.

Q. On page 131. Just let me know once you're there.

A. I'm there.

Q. Okay. So do you see the underlined passage in the second to last paragraph on the last column?

A. What I underlined?

Q. Yes.

A. Yes.

Q. Yes. I assumed, but it came to us with the underline

so --

A. It wasn't a used book.

Q. Okay. And this is one of the passages that you cited in your addendum, correct?

A. Yes.

Q. And the header for the subsection that it falls under is feticidal techniques, correct?

A. Right. Where they intentionally are ending the life of the fetus.

Q. Sorry, I'm dealing with a last bit of crud from a cold so I apologize for coughing in your ear.

A. I'm about a week from getting over mine. So no apologies needed.

Q. Thank you. So I'm going to read the first full paragraph of that subsection and I'll ask you whether I have read it correctly.

A. Okay.

Q. So it says the degree of softening of fetal cortical bones affect the amount of dilation needed for D&E. Softening is facilitated by fetal demise. Noticeable cortical softening begins to occur as soon as 16 to 24 hours after demise. The most common pharmacological agents used to induce demise in developed countries are potassium chloride, KCl, and digoxin and then parentheses Chapter 12.

Have I read that correctly?

A. Yes. Although mine says Chapter 11.

Q. Mine does as well and I appreciate you catching my typo in my head.

A. No worries.

Q. So this paragraph of the textbook is referring to cortical bone softening as a result of fetal demise induced by the abortion provider, correct?

A. Yes. They actually, before doing the abortion, the induced abortion, they actually either gave digoxin or potassium chloride that immediately stops the heart and then the baby dies.

Q. And so to clarify, so we're not talking about a situation with spontaneous fetus demise, right?

A. Correct.

Q. And not talking about cortical softening in that context, correct?

A. Not in this particular paragraph.

Q. Exactly. Are you aware of any research comparing the rate of cortical softening in the D&E setting to manage spontaneous abortion, as opposed to the rate of cortical softening in the setting of D&E for induced abortion?

A. I cannot say that I have read a study or I have looked for a study. I have read in various sources, including later in this book about, you know, just the statement of cortical softening after a fetus demise. And I have definitely

witnessed it many, many times when a woman has a spontaneous loss.

Q. And when you say you have witnessed it many times, do you mean in your experience in practice?

A. Yeah. So when doing inductions and the babies are born and their heads are very crushed.

Q. And for the various sources that you -- when you said various sources including the textbook, what other sources are you referring to?

A. So throughout the years there is textbooks that we have had in our training and -- gosh, various papers that -- where people almost -- almost like they say later, I think it's 158 they talk about softening of cortical bone makes it easier to do it. I'm trying to think if ACOG's second trimester bulletin talks about that. But there's a wide variety of places where, you know, it's almost in passing. This happens, you know.

Q. Thank you. So I'm going to turn now to page 157 of the textbook excerpt.

A. Okay.

Q. And again, I'm going to read a passage aloud and then I'll ask you to let me know if I have read it correctly.

A. All right.

Q. And I'm going to be looking at the last paragraph in the right-hand column. So it says surgical evacuation of a

nonviable pregnancy by suction curettage is performed in a fashion similar to first trimester pregnancy termination, parentheses, chapter nine. It is readily accomplished in an outpatient facility, except in cases of severe maternal disease or serious pregnancy-related complications.

Did I read that correctly?

A. You did.

Q. Thank you. And do you agree with that statement?

A. So not for me personally. I choose to do -- have chosen over the years to do my first trimester miscarriages, and that's what this is specifically talking about is first trimester, in an ambulatory surgical center or a hospital because of the risk of hemorrhage, the risk of uterine perforation, anesthesia risk, pain control risk. All those things. So I recognize that some other people may choose to do them in an outpatient setting, but I do not.

Q. So your practice is -- sounds likes your choice for where you do this is different than what they describe there?

A. Well, I think my choice and I think the majority of ob-gyns actually practice in a setting -- do their miscarriages first trimester in -- not in their clinics. And I know Dr. Boraas talks about that, and I even think in her C.V. she's given a talk called something along the lines of don't be afraid to do miscarriages outside the first trimester outside of your clinic setting. So...

Q. So I'm going to continue on with the same paragraph in 157.

A. Okay.

Q. And we are still at the last paragraph in the right-hand column. So it says with some nonviable pregnancies, the cervical softening associated with normal pregnancy is absent or minimal, making mechanical dilatation more difficult. Pretreatment with osmotic dilators or Misoprostol may help in those circumstances, parentheses, chapter nine.

Did I read that correctly?

A. Yes.

Q. And do you agree with that statement?

A. I do agree with that statement. As we talked about last hour, not all women will have -- will start having their cervix changing, and so sometimes you do have to use a mechanical prep, Laminaria, or the Misoprostol to help soften the cervix.

Q. Thank you. And then I'm going to be continuing on in that same paragraph and then into page 158.

A. Okay.

Q. So it says, quote, in contrast, when the spontaneous abortion process has already begun, the cervix is often dilated to some extent rendering mechanical dilatation easier. Although placental tissue may be more tenacious and difficult to evacuate with some nonviable pregnancies, no studies show an

increase in incomplete procedures for nonviable gestations compared to abortion of apparently normal pregnancies.

Did I read that correctly?

A. Yes, you did.

Q. And do you agree with that statement?

A. You know, I agree that -- kind of let's take it in two parts. In contrast, when the spontaneous abortion process has already begun, the cervix is already dilated to some extent rendering mechanical dilatation easier. Yeah. I mean, it's always a pleasant surprise when you go in the operating room and you think you're going to have to use your Pratt dilator to serially dilate and wa-lah, she's already open. It does make it easier because we know that the mechanical dilatation is where the potential for uterine perforation can occur. So yes.

The second one, although placental tissue may be more tenacious and difficult to evacuate with some nonviable pregnancies, no studies show an increase in incomplete procedures for nonviable gestations compared to abortion of apparently normal pregnancies. I would have to say I have not seen any studies myself. I will say this text is an older text and so there may be studies now. But I am not aware of them at this moment that I have looked in particular for.

Q. Thank you. So the quote, and then you have described to us, referred to cervical dilation that can make that mechanical dilatation easier. Is there any other way that the

textbook pages you provided to us identify that might make the procedure technically easier with spontaneous abortion?

A. Specific to these pages? I would have to review them to answer that. Would you like me to do that?

Q. I think we can come back to it. So is there -- there's nothing that comes to mind at this point?

A. Not specific to the pages I gave you.

Q. Thank you. Based on the passages in the textbook that you cited, so those three that I reviewed at the outset, including that bolded passage, would you agree that there are some circumstances in which procedural management of miscarriage is more difficult than a procedural induced abortion?

A. So that is a massively hypothetical question. And so I think every situation is unique and you can prepare and expect for various technical difficulties patient by patient. So I can't say -- answer that question the way you have answered[sic] it. I can say overall when you look at induced abortion compared to miscarriage, there are technical differences that make it more risky, particularly in the second trimester to do induced abortions.

Q. So let me then -- just because that was a longer paragraph, I'm going to pull it back and ask a shorter question. So would you agree that there are some circumstances in which procedural management of miscarriage is more difficult

than procedural induced abortion in some circumstances or any circumstances?

A. So procedural meaning a surgical?

Q. Yes. I'm sorry. Yes, I will work on making that change. So would you agree that there are some circumstances in which surgical management of miscarriage is more difficult than surgical induced abortion?

A. I can't say I would agree to that because each case is unique. But I guess I'm replicating myself, but I'll go back to say that there are more inherent risks to -- when you're doing an induced abortion with a live baby who -- I think it's in Dr. David Grime's words, at that stage of the pregnancy is tenaciously trying to stay in place. And then a situation where the fetus has already died and physiological changes are already happening, particularly a change in blood flow leading to the changes we see in the fetus. So, you know, I think I can only answer that globally. But yes, can you have a difficult D&C for miscarriage? Yes. And can you have a straightforward -- D&E, I should say, for an induced abortion? Yes. But we're talking -- we're not talking about one unique case. We're talking about the overall risk. And, you know, I clearly stand by my expert report that there are much greater risks due to the physiology that's going on with an induced abortion.

Q. Thank you. And looking back to the inherent risks

that you just mentioned. Are you referring to the risks that are the result of less cervical dilatation in induced abortion patients?

A. I'm really referring to the fact that there are greater risks for hemorrhage when you -- in the second trimester induced abortion. I'm talking about the fact that you have bones that have not -- you're having to dismember the fetus and disarticulate joints. And that's very different when you don't have a body that's already dead and macerated.

Q. Are you -- but you're not aware of research -- I'm sorry, let me back up. So you have been describing the experience that you have seen -- talking about the textbook. You're not aware of research stating that D&E for induced abortion is riskier than D&E for spontaneous abortion at the same gestational age, is that correct?

A. I'm not saying that I have seen a head-to-head study in terms of that, but there's a whole lot of anecdotal experience, even, you know, individuals who have done complex family planning rotations, you know, talking about dialogue with, you know, people, you know, so...

Q. Thank you. I am not trying to beat a dead horse here with some of these follow-up questions. I just want to make sure that we are talking about the same thing and have a common understanding of the full range of information you're talking about. And so the anecdotal experience that you're referring

to is not your own direct experience since you have never provided a D&E for induced abortion, is that correct?

A. So it's really reading case reports from other people, it's an interest in learning about it because I care about the safety of both my patients. Unfortunately the Society For Family Planning is very exclusive, so I can't become a member and learn some more of these, hence I ordered this text. It's just like anything else in our field. There's so many different areas to learn about. I'm a lifelong learner. I'm continuing to learn and want to continue to learn, and I think the vast experience I have in the operating room, particularly with miscarriages, as well as on labor and delivery with demises or previable inductions, I think allow me to have a lot of knowledge in this area.

Q. And so the case reports that you reference, you haven't cited those case reports or other sources in your expert report, correct?

A. No, I have not.

Q. Can you think of any of those sources just sitting here today?

A. I think the one that jumps off at me is a case report series of two women who had placenta previas and showing that with expected management -- of course making sure they didn't get DIC -- showing -- I think I mentioned this earlier, how much the placenta shrinks because it losses its blood supply,

and them noting when they did the D&E procedures that they had much less bleeding than they would have even expected because of the placental atrophy. That one jumps off.

Q. And where was that one from?

A. I could get that to you. I don't know off the top of my head.

Q. Okay. We'll ask Mr. Boyle to follow up with you about that.

A. Sure.

Q. And you mentioned placenta previa. So those are complicated cases, is that correct?

A. Well, yes. If you have a placenta over the cervical os it is complicated. But it is -- their point that they were making in it was that they could reduce the complication of hemorrhage from a placenta previa by reducing the blood flow and the size of the placenta. So not immediately doing the D&E. And so what it does is you can use it to show that the physiological changes that make it more risky to do a procedure like induced abortion the second trimester, the physiological changes that support that is what I'm using that for.

Q. Thank you. And can you think of any case studies, just following up, as you sit here today, involving non-complicated pregnancies to suggest that the risk of hemorrhage is greater with induced abortion than with spontaneous abortion?

A. I can't think of case studies. I have talked to MFMs about it so in the past. I have talked to general ob-gyns about it. But from a literature standpoint, I can't think of something off the top of my head right now.

Q. Thank you. And then just one other from a literature standpoint question. Sorry. Are you aware of research comparing the risk of hemorrhage as a complication for D&E for miscarriage management to the risks of hemorrhage as a complication of D&E for induced abortion?

A. Could you repeat it? Am I aware of which?

Q. Sure. Are you aware of research comparing the risk of hemorrhage as a complication of D&E for miscarriage management to the risk of hemorrhage as a complication of D&E for induced abortion?

A. The main literature in that area is not comparing those two. It's really just showing that as gestational age increases, so does risk for hemorrhage. And so that's the emphasis of those studies.

Q. All right. And when you say the main researcher of those studies, are there specific studies that you're referring to?

A. There are.

Q. Are there any -- same question. Any that you can think of as you sit here today?

A. I think I document some in my expert report.

Q. Are there studies that you can think of beyond that? I'm just wanting to make sure that we have the universe of information for that.

A. I will not claim that my expert report is inclusive of every study. It's only, I think, 30 pages long. So there are other studies I have read and I just summarized.

Q. Thank you. So I'm going to return us back to the textbook and back to page 158.

A. All right.

Q. And we are now at the top of the left-hand column in the first full paragraph in that column beginning with the phrase uterine evacuation.

Do you see what I'm referring to?

A. Yeah.

Q. Is this the passage that you cited to in your addendum -- or a passage that you cited to in your addendum?

A. It is.

Q. And specifically you cite the sentence that reads uterine evacuation may be technically easier after fetal demise. Softening of cortical bone makes surgical extraction easier. With medical aborted patients, induction abortion intervals are often shorter, parentheses, Chapter 11. Is that correct?

A. Yes.

Q. And did I read that correctly?

A. You did.

Q. So I'm going to continue reading in that same paragraph. Quote, regardless of the evacuation method chosen, patients with second and third trimester fetal death may require evaluation for coagulopathy, in addition to routine preoperative laboratory tests. Dead fetuses retained in utero for four weeks or more may cause consumptive coagulopathy, a condition that can lead to severe perioperative hemorrhage. Clotting factor therapy prior to uterine evacuation avoids this complication.

Did I read that correctly, other than almost certainly mispronouncing coagulopathy because I can never say the word?

A. It's not an easy one. I think you did pretty good. Coagulopathy. Yes, you read it correctly.

Q. Thank you. And do you agree with that passage?

A. Yes, I agree that you do not want a woman to have a coagulopathy and it rarely happens. Four weeks is an awful long time. And so, you know, most women know way beyond four weeks, but you do occasionally have a woman who has DIC and you have to take care of her. But to try to generalize that to mean that a missed abortion leads to a coagulopathy more easily and that's what happens in real life ob-gyn is just not true. But I do think it is warning you that you need to pay attention to the fact that you should do lab work and make sure that a woman doesn't have severe anemia, she doesn't have low

platelets, particularly if let's say she comes in and she's supposed to be 20 weeks and her baby is only measuring 16 weeks, then that maybe died a month ago and you're going to, you know, know a little bit more than that. So fortunately, this is very rare, but when it does happen, it does increase her risk for hemorrhage.

Q. Thank you. And I think that you answered my next question, but just so that -- just so that I'm clear. So is consumptive coagulopathy the same condition as DIC?

A. Yes.

Q. Thank you. So just some general stuff about the textbook and it may be that you refer to the inside cover for some of this, just as a heads up. But it was published in 1999, is that correct?

A. Yes, it was. And I was intentional about getting this one, an old one for the purposes of today.

Q. Why is that?

A. A couple reasons. One is the editors are very well published and they also -- I think this was written at a time that I think I'm a lot -- I was a lot less skeptical. I think they would be more honest in a way a lot of publications are written today. Not that abortion has not historically been political. But when you look at the writings, even the textbooks when I was a resident in '97 to 2001, which this would have been published during that time, it seemed to be

much more objective. There is so much publication bias that's happening right now, difficulty getting things published if -- if the society owns the journal and they don't have the same belief structure as you. I have lost trust sadly. You know, I have a Ph.D. and I don't think some of the integrity we used to have, we still have in medicine. I have sadly seen ACOG make some changes in things that I don't think are science based. And so I intentionally did an older textbook hoping to see a little more objectivity. And so, yeah, that's why I chose it. And a second reason, Dr. Boraas has a book -- a chapter coming out in a surgical gynecology book and she's talking about surgical complications in her chapter and it's not going to be published until March. So couldn't access that one.

Q. Thank you. And I appreciate you explaining the thinking behind choosing a textbook from that time period. So medical education -- medical education in 2024 isn't exactly the same as in 1999, correct?

MR. BOYLE: Objection.

THE WITNESS: A whole lot of it is the same. A whole lot of it is the same. Now, what's different? Is first day of my rotation, third year of medical school, I was told I was entering the most unique specialty in all of medicine because I got to take care of two patients simultaneously, a maternal and a fetal patient. Same thing was repeated to me two years later when I was starting residency and I was an

intern in ob-gyn. That's changed. Sadly the absence of acknowledgment of our fetal patient and trying to normalize that has changed. But so much of this textbook is very true still today. So I would disagree with your statement.

BY MS. PAI-THOMPSON:

Q. Thank you. I'm switching topics again and then I'll just flag -- you may be wondering in terms of our break. I think we'll take our next break after we get through this set of questions.

A. That will be fine.

Q. So I'm going to be talking about the subject of live birth. Are you aware of any live births that occurred following a D&E procedure as opposed to an induced abortion?

A. Yes.

Q. Let me re-ask the question because I just want to make sure I have the wording clear. Are you aware of any live births that occurred following a D&E procedure as opposed to an induction abortion?

A. I think it's much more common with an induction abortion, which is actually why people will sometimes -- clinicians will use feticide before because it's the concern of a live birth. And then they would actually have -- they would have failed their intention of the procedure and they would have to hopefully care for that newborn. But yes, I am aware of people who have survived the other type, a dismemberment

procedure, D&E.

Q. And so when you're saying that -- what -- for the cases that you're aware of, how are you aware of those?

A. Just have heard their story. Like I think one is a public speaker and I think doesn't have an arm.

Q. Do you know at what gestational age that their live birth occurred?

A. I don't.

MS. PAI-THOMPSON: I think this is a good time for our next break. Does 10 minutes work again?

THE WITNESS: Sure.

MS. PAI-THOMPSON: Mr. Boyle?

MR. BOYLE: Yeah.

MS. PAI-THOMPSON: And then I'll just also, for our court reporter, ask for a time check when we come back.

- - -

(A break was taken - 4:01 p.m. - 4:13 p.m.)

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MS. PAI-THOMPSON: Dr. Bane, I'm going to direct you now to the Desai study that you cited. I'm going to drop that into the chat and ask that it be marked as an exhibit for the deposition, but then we'll go off of our paper copies.

- - -

(Document marked as Exhibit-29 for identification.)

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THE WITNESS: Sorry, I'm just trying to locate it.

MS. PAI-THOMPSON: Absolutely. Let me know when you have it.

THE WITNESS: I have a hard copy of it. I'll pull it up. It's fine.

MS. PAI-THOMPSON: Okay. Let me know when you have it up.

THE WITNESS: Let me just see something real quick here. Maybe it's in this one. Do you mind just screensharing it?

MS. PAI-THOMPSON: Absolutely. For some reason Acrobat is not giving me that field to screenshare. So I think what we're going to do is I will move on while I also figure out why Acrobat is behaving that way. Oh, perfect. Actually I have a colleague who is going to screenshare who is not having the same issue as I am.

THE WITNESS: Okay.

MS. PAI-THOMPSON: So I think Hannah is going to screenshare and let me know when you can see the document up.

THE WITNESS: Not yet. And I'm still looking too. Still just the four of us on the screen.

MS. PAI-THOMPSON: Okay. Let's do this --

never mind. Okay. Fabulous. It has taken over my entire screen and that I don't want.

BY MS. PAI-THOMPSON:

Q. All right. So looking at -- we're going to begin with the first page here. The study that Desai and colleagues did, the study's aim as it's described in the objective was not to assess why providers did or didn't provide abortion, correct?

A. No, that was actually not done in this study. It was actually done --

Q. I'll have a follow-up question to that. So the question of why in this study, they only put that question to a smaller subset of the participants, correct?

A. I'd have to review it to know that they did a subset. I just recall the Grossman study being able to have statistics as to why. I don't recall that in this one.

Q. Okay. Well, let's go to then table one, which is at the very last page of this study. And it will be a landscape view rotation.

So looking at the top of the table which describes -- gives us the results from the study about why people didn't provide abortions. It describes the table as the percent distribution of reasons cited for not providing abortion referrals among obstetrician-gynecologists who do not perform abortions, by type of survey response correct?

A. Yeah. Can the person make it a little bigger? These

are trifocals. I need a little more. Yeah. Great. Thank you. That's plenty.

Q. Okay. So I read that correctly, right?

A. You did.

Q. So this is describing results from people who indicated that they did not perform abortions and were then asked the follow-up questions about why, correct?

A. For this subset of it looks like 271 people.

Q. Correct.

A. There were over 800 initially. So I'm not sure why it's just this subset.

Q. We'll get into that. So looking at this 271 of all respondents in that subset, you see that there are initial respondents and there were 81 initial respondents. I'm sorry, 58 initial respondents, correct?

A. Yes.

Q. And then 213 follow-up respondents, correct?

A. Yeah. But I would have to see the study to know what the difference in the two are.

Q. So of these smaller subsets that's discussed in table one for the -- I'm going to be in the all respondents column. The 16 -- it was 16 percent of that smaller subset that identified personal, moral, or ethical objections, correct?

A. I have a moral or ethical objection to abortion. 16 percent, right.

Q. And then of that smaller subset, 17 percent identified office policy, correct?

A. Office -- my office has a policy specifically against discussing abortions, 17 percent.

Q. Correct. And then 14 percent identify N/A, not applicable. I have not encountered a patient seeking abortion at this office, correct?

A. Correct.

Q. And then nine percent identified, quote, my office staff is against abortion, correct?

A. Correct.

Q. Eight percent, I do not know any abortion providers in my area, correct?

A. Correct.

Q. And two percent, my community is against abortion, correct?

A. Correct.

Q. And things like office staff and community being against abortion, those can be caused by abortion stigma, correct?

A. So, I mean --

Q. My question is they can be caused. I'm not asking you to say what would occur in every case. But they can occur because of abortion stigma, correct?

A. The reason why they're not done in an office?

Q. Or why staff would be against.

A. Well, I mean, I think the stigma is potentially more on the patient side that I think has to go away in terms of I think we stigmatize when we're with unplanned, unexpected pregnancies.

Q. My question though is about the choice that an office might make.

A. Okay.

Q. Policy to not provide abortion could be the result of community stigma in the community that that office is in, correct?

MR. BOYLE: Objection. You're asking this doctor what now?

MS. PAI-THOMPSON: I will repeat my question.

BY MS. PAI-THOMPSON:

Q. My question is -- and we're looking at, again, the 17 percent of that smaller subset that identified an office policy as the reason that they don't provide abortion. So we have that 17 percent. Okay.

A. Okay.

Q. For an office that is situated in a community that is against abortion, that can contribute -- against abortion where there is abortion stigma, that can contribute to choices around office policy, such as not providing abortions, correct?

MR. BOYLE: Objection. She's not an expert --

MS. PAI-THOMPSON: I'm going to object to speaking objections. If the objection is to my form, we'll note that. But my question stands and I would ask the witness to answer.

MR. BOYLE: Object to form.

THE WITNESS: Okay. So I can't say I agree with you in terms of knowing how this person interpreted their decision to do an induced abortion based on the community they live in. I can't -- I don't know what was going through that person's head. I can't claim that it was stigma that they may experience. Perhaps it is an influence of the community making them think, boy, the direct and intentional killing of another human, maybe that isn't a good thing to do. But they haven't got to the place where they morally or ethically object. So I really don't think I can say I know the reason is stigma.

BY MS. PAI-THOMPSON:

Q. So I'd like to talk -- referring to -- you mentioned the person who's providing the abortion and directing you again to the column in table one about follow-up respondents.

A. Okay.

Q. At the bottom it describes -- at the very, very bottom of the page that begins follow up.

A. Yes.

Q. And it says, quote, follow up respondents are those who provided information during telephone follow-up, correct?

A. Yes.

Q. So that's giving us that the 213 out of 271 respondents were those who provided information during telephone followup, correct?

A. Yes.

Q. I'm going to refer you, and then my kind colleague who is helping me out, to page three. And we'll go to the bottom of the second paragraph on page three. All right. And in that section this study describes, quote, information obtained during followup was provided by office staff rather than physician as surveyors were seldom, if ever, connected to the physician by phone, correct?

A. Yes. That's correct.

Q. So this 213 out of 271 number of follow-up respondents, those are not actually opinions directly expressed by the physicians to the researchers, correct?

MR. BOYLE: Objection.

MS. PAI-THOMPSON: You can answer the question.

THE WITNESS: Could you repeat it, please, Vanessa?

MS. PAI-THOMPSON: Sure. I can back up.

BY MS. PAI-THOMPSON:

Q. So page three, the study discloses that information obtained during phone followup, which is the phone followup that they refer to at the bottom table one, that followup

respondents were those who provided information during telephone followup, again, the bottom of page three, the page that we have up, that information obtained during phone followup was provided by office staff rather than physicians and surveyors.

MR. BOYLE: Objection.

BY MS. PAI-THOMPSON:

Q. Seldom, if ever, connected to the physician via phone, correct?

MR. BOYLE: Objection. You can answer.

THE WITNESS: I agree with what you're reading. I don't know if there's another question in there.

BY MS. PAI-THOMPSON:

Q. So the question was do you agree with my reading and as you -- let me actually withdraw that question.

So it's common as part of a study that the researchers will describe their process, correct?

A. The method is that process, yes.

Q. And you don't have any reason to believe that in this study the processes that they described in the article are accurate, correct?

MR. BOYLE: Objection.

BY MS. PAI-THOMPSON:

Q. Do you have any reason to doubt that they described what they did in the method section?

A. I don't have any reason to doubt if that's what they're describing. I have a lot of concern about their methodology though.

Q. My question though was whether they described their methodology in the method section.

A. So it would have been nice to know what office staff is, but you don't want me to go there yet?

Q. I'm just going to refer us back then to -- and you have answered this question already, that I have read correctly the section where they discussed information during follow-up, correct? At page three at the bottom of the second paragraph.

MR. BOYLE: Objection.

THE WITNESS: So Vanessa, the only thing I would agree with right now is I have some concerns about, you know, the figure and this methodology, but I agree that you have read that last sentence correctly.

BY MS. PAI-THOMPSON:

Q. The study also focused only on private practice, correct?

A. Correct.

Q. And it specifically excluded ob-gyns who practice in clinics, correct?

A. Practice in clinics? What do you mean by that? Are you talking about academic?

Q. What's that? A clinic like Planned Parenthood, they

specifically excluded from this study participants -- or providers who practice in clinics?

MR. BOYLE: Objection.

THE WITNESS: I would need to review to be able to answer that. I know it's private practice.

BY MS. PAI-THOMPSON:

Q. So we're at the top of the same page, the second sentence -- I'm sorry, the first sentence. Physicians who are clinic based, retired or deceased or did not provide accurate contact information were excluded from the sample. Prior to mailing the survey, 29 physicians were identified as clinic based and were removed from the sample, correct?

A. What you're reading is correct, but I don't know how they define clinic based in this study.

Q. Well, we can move on and then we can go back to that. I'm going to move on now to Grossman.

A. Okay.

Q. Yes. And I'm going to -- do you have the paper copy of that handy?

A. I don't. You'll need to share that.

Q. Okay.

MS. PAI-THOMPSON: And I'm also going to drop that in the chat and ask that it be moved as an exhibit.

- - -

(Document marked as Exhibit-30 for

identification.)

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BY MS. PAI-THOMPSON:

Q. Do you have it in front of you or are we screen sharing?

A. I don't have anything in front of me yet, but it took a minute for it to come up last time. Here it comes. I have it.

Q. Okay. So again with Grossman, they did not identify as their reason, their purpose in performing this study discerning why people chose not to provide abortions, correct?

A. I think that was an element of it, that they did that.

Q. They did do it, but it was not identified as a reason --

MR. BOYLE: Can you let her finish her answer, please? She was not finished.

THE WITNESS: So I think that if you look at just their objective to estimate proportion of obstetricians, gynecologists who provide induced abortions in the prior year and document -- disaggregated by surgical and medication methods and document barriers to provision of medication abortion, I think that is an element of the why.

BY MS. PAI-THOMPSON:

Q. And so it actually was -- you brought up the objective piece. It was in the documenting barriers to provision of

medication abortion. That was actually where they asked the question why, correct?

A. I would need to review their methods one more time.

Q. I will focus you on something as you do that. That here the smaller subset of participants they asked the why question to were participants who did not provide medication abortion, correct?

A. I would need to review the methods to know that for sure.

Q. So at table four in this study. And this is the table that gives us that 34.2 percentage figure that you cite to in your expert report, correct? Or it reflects that figure.

A. Could you make it a little bigger for me? Yes.

Q. Again, for the why question, it gives the heading for table four that includes this data is, quote, perspectives of obstetricians, gynecologists who do not provide medication abortion among those who have patients seeking abortion, correct?

A. Correct. That's the title.

Q. So this -- according to the title, this table reflects the subset of people who do not provide medication abortion and were asked the why question, correct?

A. Yes.

Q. And in that section the most common reasons listed are discussed. And you also discuss that in paragraph 22 of your

report, correct?

A. Yes.

Q. And in paragraph 22 of your report you refer to that 34 percentage as the most common reasons for not providing abortions included personal, religious or moral beliefs against abortion, correct?

A. Yes.

Q. The study here when describing the same information actually says that it is the reasons for not providing medication abortion here, correct?

A. Yes, I stand corrected that I left out the word medication.

Q. And in addition to that 34 percent that you noted referenced moral reasons in that table we see that probably 19 percent reference practice setting restrictions?

A. Yes.

Q. And 16 percent reference office staff attitudes?

A. Yes.

Q. Do you believe that abortion providers experience more or less verbal harassment than physicians who do not provide abortion?

MR. BOYLE: Objection.

THE WITNESS: I have no way of answering objectively that question. I will tell you that there's stigma in various aspects of medicine. I'm stigmatized often being a

medical director for Pregnancy Centers. ACOG has called me unethical in their issue brief about Pregnancy Centers. So I think stigma is wrong regardless of who is getting it. But whether it is somebody who is trying to practice from a life-affirming approach like myself or -- I don't think individuals who provide abortion should be stigmatized. But I cannot tell you they are more stigmatized than other people are.

BY MS. PAI-THOMPSON:

Q. You're not aware of any other specialty other than providers who provide abortions in which physicians have been murdered for the medical care they provide, are you?

MR. BOYLE: Objection.

THE WITNESS: I don't know the answer to that question.

MS. PAI-THOMPSON: I'm going to move now to the Niinimaki study and the letter to the editor. And I'm going to drop both of those into the chat and ask that they be marked as exhibits.

- - -

(Document marked as Exhibit-31 for identification.)

- - -

BY MS. PAI-THOMPSON:

Q. Do you have those in paper copy or do we need to --

A. No, I actually have -- I have Niinimaki. I don't have the second part.

Q. Okay. So we will get ready to screenshare the letter to the editor as needed and we'll begin with the paper itself then. So in the United States, medication abortion procedures are generally a combination -- I'm going to withdraw that question and ask it more clearly.

In the United States one commonly used regimen for medication abortion is a combination of Mifepristone and Misoprostol, correct?

A. Yes.

Q. And then another common regimen is the use of Misoprostol alone, correct?

A. Much less common.

Q. In your discussion on August 31st in your deposition, you and Ms. Salvador discussed some facets of the Niinimaki. I'm not going to retread that ground, so we'll just get into a few additional questions. The study identified medication abortion protocols that are available -- that are used in Finland that are not those two that we just identified, correct?

A. Let me review it again. I believe that they only go up to 63 days.

Q. So I'm asking just about the drugs that were used. And specifically in one instance they say that there was a

Mifepristone-only regimen that's used in Finland?

A. Yes, I do know that.

Q. During the August 31st deposition, you and Ms. Salvador reviewed the letter to the editor and we'll go ahead -- we can screenshare that as well for our reference here. And in that deposition, do you recall discussing concessions that are in the letter to the editor about limitations of the study?

A. Yes, I remember just the aspect related to hemorrhage. The study also looked at incomplete abortions and having to go back to surgery. But the letter saying that some of the people who went to the -- to follow-up care, would it truly be classified as hemorrhage as -- that was the gist of our conversation.

Q. Okay. Thank you. And do the concessions from the authors of the Niinimaki study change your opinion about the study's reliability as a source for your statement in paragraph 48 of your report that, quote, chemical abortions have a four times higher risk of complications compared to surgical abortions?

A. I think the absolute numbers may change, but I think the ratio comparing surgical abortion and medication or chemical abortion, you're still going to -- and it's not just this study. I think it's the Mintua study I also reference. We consistently see that there are higher complications with medication abortion compared to surgical. But I think the

absolute numbers would have to be reevaluated.

Q. And so is your answer that it doesn't change your opinion about the study's reliability as described in paragraph 48 or that it does?

A. It impacts it, but that piece is one part of this entire study. But I still -- with the collective body of research still, the fact that surgery -- I'm sorry, medication, chemical abortion leads to more complications I still stand by.

Q. In your opinion, in general -- is it your opinion, in general, that abortion is not safe?

A. Are we talking about induced abortion?

Q. Yes. I will rephrase. It's your opinion that, in general, induced abortion is not safe, correct?

A. It is my opinion that we need to do a much better job collecting data to make that conclusion. I think it's an assumption at this point for many different reasons that I outline in my expert report.

Q. And so when you say that it's an assumption, do you mean that it's your assumption that it's not safe?

A. It's an assumption that Dr. Boraas and Dr. Farris make throughout the entirety of all of their documentation.

Q. My question is not about the conclusion that abortion is safe. My question is about your opinion. So I'll re-ask the question. And that's why I say I might need to jump in to clarify if it seems like we're talking about different things.

My question is it's your opinion that, in general, induced abortion is not safe, correct?

A. So once again, an extremely loaded question. So it is never safe for my fetal patient, and I was taught and continue to believe, the purpose of health is for -- of medicine is for health and wholeness and that I have a maternal and a fetal patient to take care of. It is never safe for my fetal patient. I have grave concerns for keeping my patients safe who choose to have an induced abortion, and I want to do everything in my power to minimize their risk. And so that's what I can agree to you to say.

Q. Thank you.

MS. PAI-THOMPSON: I think that we will take a break here. Shall we do 10 minutes?

THE WITNESS: Okay.

MS. PAI-THOMPSON: Thank you. If I could get actually a time check from our court reporter, that would be hugely appreciated as well. Thank you.

- - -

(A break was taken, 4:43 p.m. - 4:53 p.m.)

- - -

MS. PAI-THOMPSON: And I just want to confirm also -- I'm sure that we -- I dropped -- I am going to -- because I thought I had and I hadn't, drop just for the purposes of our record, the letter to the editor into the chat

and ask that it be marked as an exhibit.

- - -

(Document marked as Exhibit-32 for identification.)

- - -

BY MS. PAI-THOMPSON:

Q. Dr. Bane, you're not familiar with the training that any Planned Parenthood South Atlantic receives regarding administering anesthesia, are you?

A. I can only talk about what -- the deposition that Dr. Farris did.

Q. Okay. So no knowledge beyond that deposition?

A. In the protocols -- I've reviewed the policies and procedures in the protocols and there's no mention of any anesthesia professionals.

Q. And so my question was the extent of your knowledge about the training that any Planned Parenthood South Atlantic employee would receive is from exclusively from the deposition of Dr. Farris, is that correct?

A. From the deposition and any policies and procedures that I was given to review.

Q. Thank you. And you don't know the sedation practices that non-Planned Parenthood South Atlantic providers in North Carolina use, correct?

A. As part of this case, there was no discovery related

to that. I can't even really talk to you about patients who have gone to some of those places.

Q. You don't have comprehensive information --

MR. BOYLE: She's not done with her answer.

THE WITNESS: Yeah. So talking about how difficult their experience was. But I do not have any documentation. I have patient anecdotal experiences.

MS. PAI-THOMPSON: Thank you. And I am just now dropping that letter into the chat. Sorry. My window had closed out.

BY MS. PAI-THOMPSON:

Q. Is it your testimony that only people who have completed a complex family planning fellowship can safely provide D&Es for induced abortion?

A. It is my testimony that the purpose of the complex family planning fellowship, above and beyond four years of training, is that there is an additional need for second trimester or third trimester abortions and then contraception is the second element. And that it is now not just resident -- or fellowship programs. It's actually a board certification. So based on that, it is my opinion that the American College -- the American Board of Ob-Gyn, excuse me, and residency programs believe that it is necessary.

Q. So my question isn't about what you believe they believe. My question is, is it your testimony that it's your

opinion that only people who have completed a complex family planning fellowship can safely provide D&Es for induced abortion?

A. At what gestation are you talking about?

Q. After the twelfth week.

A. Okay. So second trimester. I -- so repeat the question now that we have clarified the gestational age.

Q. Is it your testimony that it's your opinion that only people who have completed a complex family planning fellowship can safely provide D&Es for induced abortions after the twelfth week of pregnancy?

A. So I can't say yes or no to that question. There are --

Q. If you can't say yes or no, that's fine. I can --

A. Can I finish what I was going to say? So there are people who have 20-plus years experience and have done a tremendous amount of them, and this is a fairly new complex family planning program. I think it's only become a board certification the last few years. So I think there are people who have practiced a long time. As a matter of fact, all the editors of this book do abortions, from my understanding, or did. They're not all practicing right now. And they didn't complete the program. And so I think that you can't just make a blanket statement like that that I could easily say yes or no to. I think that it is technically a very difficult procedure,

as many people have alluded to from reading the literature. And it is a fact that our governing bodies think that we need additional training beyond four years is consistent with that.

Q. Thank you. So I'm going to refer back to the textbook. And you described that you intentionally chose a textbook from 1999. You intentionally chose a textbook from 1999, and knowing that it might not reflect the current state of medical practice, is that correct?

A. No, that's not correct at all. If you recall, I said that the names are very respected and well-known in ob-gyn. So that drew me to it. And then what drew me to it also is the fact that I felt that perhaps they would write it from a more objective standpoint than what I see so much of what's being written today. I knew there would be a critique of how old it is and I think there are some things in there that they might say we don't know this, and now I kind of can go oh, yeah, we do. But there are many things in there that are the same as what we do now.

Q. So is it your opinion that everything -- just the textbook pages that you sent us, not the entire textbook, but the textbook pages you sent to us reflects current medical practice?

A. Well, once again, I think you're trying to oversimplify the situation. For example, I think the data have changed where they say that I think it was 50 percent have not

received training in first trimester abortions. Now that number is lower. And so I think there are some shifts in even then. They -- medication abortion, chemical abortion was -- you know, it wasn't -- Mifepristone wasn't approved until 2000 and so this is written in 1999. There's a very fascinating statement in the first or second chapter that states that if medication abortion can happen before implantation, then maybe we'll call it contraception one day. And I find that fascinating because ACOG has now changed the beginning of pregnancy to implantation. So some of the story lines that I see historically playing out, the stage was set in this book.

Q. What's the basis for your belief that women receive inadequate pain management during second trimester abortion?

A. Well, I didn't -- if I came across as saying that every woman receives inadequate pain management, then I will pull back on that statement. I don't believe every woman does. I believe that pain management takes a second seat to trying to get abortions often done in a setting where you cannot do deep sedation or general anesthesia. That's the point that I made. And I also anecdotally have had patients who have talked about that they did not feel like they were adequately managed with their pain with their surgical abortions. From reading, I think it was Dr. Wheeler and Dr. Rubinhorse's expert reports, they cite studies of inadequate pain management. I did not site those studies. So it's multiple reasons. But do I

believe a woman can get adequate pain management? Yes, I do.

Q. Thank you. And you referred to the studies that Dr. Wheeler and Dr. Rubinhorse relied on. Did you review those studies or just see the citations?

A. I just saw the citations.

Q. Thank you. Was it your practice when you were providing care, was it your practice to provide either deep sedation or general anesthesia to every patient who you provided a D&E?

A. I didn't provide the anesthesia. The anesthesiologist or nurse anesthetist -- the anesthesia professional provided that. And I would say the majority chose general anesthesia.

Q. And so referring to practice statements and committee opinions that we have kind of talked about through this deposition. You agree that practice statements and committee opinions are the result of a review of the relevant literature, correct?

A. That's what they should be based on.

Q. And them being based upon that allows them to represent something close to a professional consensus, correct?

A. Could you define what you mean by a professional consensus?

Q. A general consensus among the providers for whom the body issuing the practice statement or committee opinion.

A. So I wouldn't necessarily agree with that statement.

I would agree that it is a -- it should be that. It should be a consensus of membership. It's not always consensus of membership. At the bottom of committee opinions they'll have the individuals who actually were on that committee and made that decision. And so I think a ACOG, while it does a lot of great work in areas -- some areas, I think in the -- their abortion statement they don't represent a consensus of their membership.

Q. And you referenced ACOG'S statements, you don't believe they represent a consensus?

A. Not all of them. Just --

Q. Yes. That's going to be my follow-up question to clarify. That's, as you were talking about earlier there, statements that refer to policy about abortion, correct?

A. Correct. And so, you know, I'm watching like a hawk if they -- if they make statement changes that are -- seem to be politically driven instead of science driven. And I think their abortion policy -- the way they changed it from after viability they did not support abortion for a healthy fetus. And as soon as the Dobbs leak came out they changed it to full with no barriers and no limitations. And that was like the Dobbs leak. That wasn't even the Dobbs decision. So those types of things are not professional and do not show integrity. And those are the things that I'm very concerned about.

Q. Thank you. And you sort of jumped and corrected -- I

was talking about -- you said not all ACOG statements and have described how you disagree with their policy statements. You generally think that the technical medical information that they include is accurate?

A. We'd have to go statement by statement. But the ones I chose to include in my expert report, I fully support the position they gave.

Q. And that was 191 and 193, right?

A. I think 191 was my first declaration. 193 for this one where they did an interim update.

Q. Thank you. Do you have any reason to believe that a patient is more likely to see a CFP trained physician at a hospital than at an outpatient abortion clinic?

A. You say CFP trained, are you talking about fellowship trained?

Q. Sorry. Yes. Yes.

A. So could you ask me that question again?

Q. Absolutely. Do you have any reason to believe that a patient is more likely to see a complex family planning fellowship trained physician at a hospital than at an outpatient abortion clinic?

A. I don't know the percentage of those individuals that go into academic positions. I know Dr. Boraas does a lot of her procedures in the hospital. But I don't know the statistics for what their -- where their graduates go.

Q. Thank you.

MS. PAI-THOMPSON: And I have no further questions at this time.

BY MR. BOYLE:

Q. Doctor, good afternoon. My name is Ellis Boyle and I represent the defendant intervenor legislative leaders and I would just like to ask a few questions. Could you please tell us if you have any concerns with the Desai conclusions from that study?

A. So we never got to kind of what my concerns were, but I think from a methodological standpoint they have very different ways that they are getting to their data, and the fact that one is a survey that's likely anonymous versus a telephone call. We know that individuals are more honest and feel free to give their opinions when they're doing an anonymous survey or a survey that no one -- they don't have to attach their name to it, versus I pick up the phone and I say hey, why don't you do medication abortions was the table -- was it medication abortions for that particular study? And so I -- I have a problem with that. And then, you know, I do think that there are multiple reasons why ob-gyn physicians do not choose to do abortions, but I think we have to be careful that just -- while a third of them stated specifically I have moral or ethical objections, the fact that they have chosen a practice which they knew didn't do them, then that's also an

indirect reason that -- they knew they weren't going to be able to do them, so that also goes towards those numbers. And so I think we just have to weed out and cipher out that study better, which we didn't really go into.

Q. And not to be too broad, but there were some other studies that you were asked about in the textbook. Was there anything that you wanted to followup and say -- that you would like to have the opportunity to say now about what you were asked about for the previous three hours?

MS. PAI-THOMPSON: Objection to form.

THE WITNESS: Not that comes -- I can think of right now.

MR. BOYLE: Okay. I don't have any further questions. Thank you.

MS. PAI-THOMPSON: I have no further questions either. Thank you.

MR. BOYLE: Anyone else?

MR. BULLERI: I do not have any questions. Thank you.

- - -

(Witness excused.)

- - -

(Deposition concluded 5:11 p.m.)

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CERTIFICATE OF REPORTER

STATE OF NORTH CAROLINA)

COUNTY OF ALAMANCE)

I, Susan A. Hurrey, RPR, the officer before whom the foregoing remote deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me to the best of my ability and thereafter reduced to typewriting under my direction; that the witness reserves the right to read and sign the transcript of the deposition prior to filing; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken; and further, that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.

This the 13th day of February, 2024.

_____

SUSAN A. HURREY, RPR

Notary Public #201826800211

I, SUSAN BANE, M.D., Ph.D., do hereby state under oath that I have read the above and foregoing deposition in its entirety and that the same is a full, true and correct transcript of my testimony, subject to the attached list of corrections, if any.

_____

SUSAN BANE, M.D., Ph.D.

STATE OF_____

COUNTY OF_____

Sworn to and subscribed before me this_____day of_____, 20_____.

_____

Notary Public

My commission expires:_____

E R R A T A S H E E T

PAGE LINE CORRECTION

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I, _____, after having read the foregoing transcript of my deposition, wish to make the above corrections.

SIGNATURE_____

DATE_____

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DISCOVERY

COURT REPORTERS AND LEGAL VIDEOGRAPHERS

ERRATA SHEET FOR THE DEPOSITION OF:

Deponent: Susan Bane, M.D., Ph.D.

Case Name: Planned Parenthood South Atlantic, et al. v. Joshua Stein, et al.

Date of Deposition: 01/31/2024

CORRECTIONS:

2 4

Page	Line	Now Reads:	Should Read:	Reason Therefor:
30	6	included in ACOG cog	Included in ACOG	Extra word
48	24	trachea	tracheostomy	Wrong word
69	6	is	are	Grammar
73	18	answered	asked	Wrong word
75	16	I am not saying	I am saying	Incorrect
107	23	Rubinhorse's	Dr. Wubbenhorst	Spelling
108	3	Rubinhorse's	Dr. Wubbenshorst	Spelling

Signature of Deponent Susan Bane Date: 2/26/2024

ND:4875-5970-8073, v. 1